Physician Order and Parent/Guardian Authorization for G-TUBE FEEDING

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508

Student Name:_____ **DOB:** _____

Allergies:_____ **G-tube Type:**_____ **Size:**_____

The treatments needed during school hours are (please indicate):

- ☐ Feeding by gravity ☐ Feeding by pump Type of Pump: _____
- ☐ Blended Diet Syringe Bolus
- ☐ G-tube medications – Please list drug, dose and frequency: _____

Procedure for feeding administration:

1. **Position student**
   - ☐ Sitting upright or semi-reclining with head at_____degree angle - OR -
   - ☐ Lying on right side with head elevated at_____degree angle – AND -
   - ☐ Remain elevated for _____minutes after feeding is administered.

2. **Aspirate - Check one:**
   - ☐ I **DO** order to check for aspirate. If aspirate is greater than_____ml ☐ Feed ☐ DO NOT feed
     ***Delay feeding for_____minutes, and repeat aspiration.
     ***If aspirate continues to be greater than_____ml contact parent.
   - ☐ I **DO NOT** order to check for aspirate.

3. **Flushing – Check one:**
   - ☐ I **DO** order G-tube to be flushed ☐ Before feeding or medication with_____ml of free water.
     ☐ After feeding or medications with_____ml of free water.
   - ☐ I **DO NOT** order G-tube to be flushed

4. **DIET** Student is allowed to eat/drink by mouth: ☐ **Yes** ☐ **No** ***If Foods need to be modified/thickened/pureed, please complete **Food Service Modification Form**

   Type of Feeding:_____ **Amount:**_____ **Frequency:**_____
   (Feeding Formula must be sent to school in labeled container with ingredients listed.)

   ***Please give_____ml of free water at (indicate time)_____AM and/or_____PM.**

5. **COMMENTS:** _____

Parents will be notified immediately if tube becomes dislodged. It is recommended that a replacement tube be kept at school in the event of tube dislodgement and parent is called to replace it. School Staff are not able to replace tube.

X _____ _____
(Physician's Signature) Date

_____ _____
(Physician's Name - Printed) Telephone Number

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of_____, hereby request the School Nurse or trained staff member to administer the above procedure(s) and medication(s) according to the Physician's instructions. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

*****I agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders.**

Parent/Guardian Signature:_____ **Date:**____/____/____

Parent/Guardian Name: _____ **Phone:** _____ **Cell:** _____

Reviewed by:_____***RN*** ***Date:*** _____

Fayette County Public Schools
FEEDING PLAN

Student Name_____DOB_____Age_____Grade _____

School_____Teacher _____

Parent(s) _____

Phone (Home)_____(Work)_____(Cell) _____

Primary Physician_____Phone _____

Current Medications: _____

_____

Medical Equipment in use: _____

Precautions/Emergency Procedures related to feeding/swallowing: _____

_____

DIET: ***attach physician's or medical dysphagia team's orders

_____full tube feeding (____G tube_____J tube)
_____full oral feeding
_____mixed oral/tube feeding (describe_____)
_____parent/guardian provides meals/snacks
_____regular school meals/snacks
_____modified school meals/snacks (**FOOD SERVICE MODIFICATIONS** form required)

Food/liquid content/quantity _____

_____

Food/liquid texture (clarify terminology used and preparation method) _____
_____
_____

Feeding schedule _____

SPECIAL EQUIPMENT:

For food preparation _____
For feeding _____
For oral hygiene _____

SEATING

_____regular seating
_____wheelchair_____at table_____tray attached
_____special seating (describe_____)

POSITIONING:

_____independently upright
_____supported upright (how? _____)
_____independently reclining (how?_____angle_____)
_____supported reclining (how?_____angle_____)
_____side lying (specify side_____)
_____prone
_____supine
_____other (describe _____)

FOOD PRESENTATION

_____bottle_____cup_____straw_____spoon_____fork_____knife_____bowl_____plate Volume of food/liquid per presentation _____

If child is fed, name and title of feeder(s) _____
_____

Placement of feeder/assistor (location and proximity to child _____
_____

Placement of feeding implements _____

FEEDING PATTERN

Number of swallows per bolus (bite)_____
Provide_____(quantity, type) liquid after
_____(number) of food presentations.

SPECIAL TECHNIQUES

_____head tilting at_____angle_____to left_____to right
_____head turning to_____left_____right
_____chin lift
_____chin tuck
_____holding breath during swallow
_____other (describe) _____

ORAL HYGIENE

_____Independently clears food from mouth
_____Independently brushes teeth/rinses mouth
_____Requires assistance by _____

Tooth brushing schedule _____
_____Has oral prosthesis or braces

Comments:

COPY TO: □ School Nurse
□ Teacher
□ Cafeteria Manager

Food Service Modification Form

This form must be completed and signed by a Physician if your student requires a dietary restriction.
(i.e. no peanut butter, no strawberries, etc.) **OR a food substitute** (i.e. allergic to cow's milk – substitute soy milk).
This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.)
This form must be completed and signed by the student's Physician to ***reverse*** **a previous accommodation** (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction" etc.)
Once the form is on file, it will remain valid until a new form is presented.

PART A

Name of Student:		**Date of Birth:____/____/____**	
Allergies:		**Is this Allergy Anaphylactic? YES NO**	
Current School:	**Grade:**	**Classroom:**	
Does student have a Disability/Special Need? Describe the major life activities affected. _____		☐ **Yes**	☐ **No**
Does student have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed Physician.		☐ **Yes**	☐ **No**

PART B

List any dietary restrictions/allergies or special diet: _____

Food(s) to OMIT : ☐Fluid Milk ☐Cheese ☐Yogurt ☐Foods/recipes with milk or milk products as an ingredient

☐Whole eggs (scrambled, hard boiled) ☐Food/recipes with any egg listed as an ingredient ☐Wheat/Gluten

☐ Oats ☐Peanuts ☐Tree Nuts ☐Whole corn (corn kernel, tortilla chips, corn muffin, popcorn)

☐NO foods/recipes with corn listed as an ingredient (corn syrup, cornstarch, etc.) ☐ Shellfish ☐Fish

☐Other:_____ **For nutrition/ingredients for FCPS meals: www.fayette.nutrislice.com**

☐ **List any foods to avoid for religious reason** ** ☐ **Pork** ☐ **Gelatin**** *Religious reason does not require Physician Signature*

☐ **Food Intolerance:**_____ ☐ **Avoid Red Dye** ☐ **Avoid Lactose**

List foods to be substituted: _____

☐**NO Substitutes required** **Please Substitute with** ☐ **Lactose Free** ☐ **Soy Free** ☐ **Sun butter**

Texture Modification:

Liquids:
- □ **Thin (Regular liquids)**
- □ **Nectar Thick**
- □ **Honey Thick**
- □ **Pudding Thick**

Solids:
- □ **Large foods cut into bite size**
- □ **Mechanical Soft (chopped)**
- □ **Mechanical Soft (ground)**
- □ **Pureed (Applesauce texture)**

List any special equipment or utensils that are needed:

Indicate any other comments about student's eating or feeding patterns:

Which meals will your student eat from the Cafeteria? ☐**Breakfast** ☐**Lunch** ☐**None** **(will bring from home)**

Parent/Guardian's Signature: _____	**Date:____/____/____**
Physician's Signature: _____	**Date:____/____/____**

REVIEWED BY NURSING: _____ ***RN*** ***DATE:*** _____