

**SAN ANTONIO INDEPENDENT SCHOOL DISTRICT**  
**Student Health Services Department**  
**ENTERAL FEEDING REQUIRED AT SCHOOL**  
**Physician Orders/Parent Permission**  
**SCHOOL YEAR 20\_\_\_\_-20\_\_\_\_**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Nasogastric  Gastrostomy  Jejunostomy Device:  Tube  Button Diagnosis: \_\_\_\_\_

**PROCEDURE:**

1. Recommended method for verifying feeding tube placement:

\_\_\_\_\_

2. Formula: \_\_\_\_\_ Amount: \_\_\_\_\_ Time(s): \_\_\_\_\_  
(Please give range of time when possible to accommodate school schedule)

3. Method:  Gravity drip over period of \_\_\_\_\_ minutes.  Feeding pump at rate of \_\_\_\_\_ ml/hr.  
After each feeding, flush the tube with \_\_\_\_\_ cc's of tap water.

4. Position child with head and upper body elevated at least 45 degrees. Keep child upright after feeding for \_\_\_\_\_ minutes.

5.  Do check for residual prior to feeding  Do not check for residual prior to feeding  
If residual is greater than \_\_\_\_\_ cc's, hold feeding for \_\_\_\_\_ minutes, then recheck.

6. If the tube becomes dislodged: \_\_\_\_\_

\_\_\_\_\_

7. If the tube becomes clogged: \_\_\_\_\_

\_\_\_\_\_

8. Clean feeding set after final feeding of the day with:  tap water only  soap and tap water.

Frequency of feeding set change: \_\_\_\_\_

Frequency of extension tubing change: \_\_\_\_\_

9. Clean gastrostomy site:  every feeding  daily  only as needed  other: \_\_\_\_\_

**ADDITIONAL INSTRUCTIONS/PRECAUTIONS:**

\_\_\_\_\_

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Phone

\_\_\_\_\_  
Office Fax

**TO BE COMPLETED BY PARENT/GUARDIAN**

I give permission for my child to receive enteral feedings as prescribed above by my child's physician. This permission is valid for any physician order change(s) during the current school year. I also give permission for the nurse to consult with the prescribing physician regarding the enteral feeding orders.

Adjustment in the feeding or discontinuation of the feeding requires a written, signed physician's order.

I will provide the required equipment and supplies to the school clinic.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Date