Houston Independent School District
Health and Medical Services

Physician Orders for Tube Feedings

To the Nurse of: ____________________School Student ID Number: ______________
Child's Name: _________________________ Date of Birth: ___________________

Diagnosis: ____________________________ Allergies: ☐Latex ☐Other ____________

Tube Feeding Route:

☐Gastrostomy tube ☐Nasogastric ☐Orogastric ☐Nasojejunal

☐Gastrostomy button ☐Jejunostomy tube ☐Nasoduoduodenal

Type of tube feeding:

☐Bolus/Gravity ☐Pump- Rate ______________ml/hour ☐Other _____________

Brand of Device: ☐Mic-Key ☐Mic G ☐Mini ☐Bard ☐Other _____________

Tube size: ________FR **Balloon volume:** _________

Formula: _____________________________________ **Premixed/prepared by Parent** ☐Yes ☐No
Amount of Formula: ______________ml
Feeding Schedule-Frequency During School Day:

☐Breakfast ☐Lunch ☐Other _______________________________________

☐Specific Times as listed _______ _______ _______ _______

☐Parent may adjust feeding schedule

Flush with _________ **ml water before and after the feeding.**
How much additional water may be administered each day at school? __________ml
Amount of food or drink that may be taken by mouth (if any): ____________________
Check residual ☐Yes ☐No
Hold feeding if residual > _____________**ml**
Vent the G-Tube: ☐Yes ☐No
Does the student have Fundoplication? ☐Yes ☐No

Precautions, possible untoward reactions and interventions: __________________________
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A registered nurse will coordinate the health care of all students, including medications, treatments, and prescribed procedures. Note: If the tube is displaced the nurse will cover the stoma and contact the parent.

Signature of Physician	**Telephone**	**Date**

I request the above procedure(s) be administered to my child as ordered by the physician. I authorize the school nurse to contact my child's physician for information concerning my child when necessary.

Signature of Parent	**Telephone**	**Date**