Tube Feedings

Student Name:	DOB:
Parent Name:	Number:
Practitioner Name:	Practitioner Number:
Allergies:	Medication:

SEE NURSE OFFICE FOR Dr's Orders

Specifics of Management: Diagnosis related to need for tube feeding:
_____

Is child allowed oral feedings? _____ Yes _____ No If oral feedings are allowed, what, if any food/fluid will be given at school?
_____

Will medications be given via tube ?_____ Yes _____ No If so, please list any specific directions_____
_____

Product to be used for tube feeding:
_____

Amount: _____

Approximate Time_____

Give by gravity_____ or bolus _____

Water flush amount_____

before feeding _____

after feeding _____ **or**

NO FLUSH _____

Additional Comments:

_____

Accommodations:

Created By:

Name:	Title:	Date:

I have read and acknowledge:

Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date:
Name:	Title:	Date: