

# Kauri Sue Hamilton School

## Order form for G/J-Tube Feeding Procedure

To be completed by the students physician or parent and returned to Kauri Sue Hamilton School: Fax (801) 567-8522 or [kshs.nurses-uc@jordandistrict.org](mailto:kshs.nurses-uc@jordandistrict.org)

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

**Tube feeding needed during school hours are (please indicate):**

- Feeding by bolus via Syringe or Bag (circle one)
- Feeding by pump @ \_\_\_\_\_ ml/hr x \_\_\_\_\_ hr(s)

**Procedure for feeding administration during school hours:**

1. **Formula:** \_\_\_\_\_
- Amount of feeding:** \_\_\_\_\_
- Time(s) of feeding:** \_\_\_\_\_
- Flush after feeding with \_\_\_\_\_ ml water**
- If needed: \_\_\_\_\_ ml of free water at \_\_\_\_\_ AM and/or \_\_\_\_\_ PM.**

**2. Position Student**

- Sitting upright or semi-reclining
- Laying down
- Any position
- Other \_\_\_\_\_

3. **GT button type and size:** Brand: \_\_\_\_\_ Size: \_\_\_\_\_ F \_\_\_\_\_ cm  
\_\_\_\_\_ (ml) volume of water in balloon

4. **Comments:** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Parent/Guardian Statement

- I, Parent/Guardian of \_\_\_\_\_, hereby request the School Nurse or trained staff member to administer the above feeding procedure(s). I agree to furnish all equipment, formula and supplies necessary for the administration of the tube feeding. **I also agree to notify the School Nurse of any change made regarding formula type, and/or amount, administration time or discontinuation of feeding.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Reviewed by: \_\_\_\_\_ RN Date: \_\_\_\_\_