Kauri Sue Hamilton School
Authorization to Administer Gastrostomy (G-Tube) / Gastrostomy-Jejunostomy (G-J Tube) Feeding Procedure

Phone: (801) 567-8500 Fax: (801) 567-8522 email: kshs.nurses-uc@jordandistrict.org

STUDENT'S NAME:_____ DOB: _____

G-Tube_____ G-JTube_____ GT button type and size:

Brand:_____ Size: _____ F _____ cm _____(ml) volume of water in balloon

FEEDING ORDERS DURING SCHOOL:

Formula name:_____ Water only:_____

☐ **Bolus feeding via syringe or bag (gravity)**

Volume (amount):_____ml over _____ minutes

- ☐ Feeding is required every _____ hours ***-OR-***
- ☐ Feeding is required at _____ o'clock (and) _____ o'clock ***-OR-***
- ☐ Feeding is required ONLY if student does not eat lunch orally
- ☐ Flush before with _____ml water and/or after with _____ml water

☐ **Feeding Pump- *Pump to be programmed by parent***

☐ **Bolus** Pump Feeding: Volume (amount)_____ml Rate set at: _____ml/hr over _____minutes

- ☐ Feeding via pump is required at _____ o'clock (and) _____ o'clock
- ☐ Flush before with _____ml water and/or after with _____ml water

☐ **Continuous** Pump Feeding: Rate set at: _____ml/hr

ADDITIONAL HYDRATION:

☐ **Water** Volume (amount):_____ml at _____ o'clock

Administer via ▢ GT ▢ JT ▢ Gravity ▢ Pump -Rate set at: _____ml/hr over _____minutes

ADDITIONAL INFORMATION:

Student may also eat orally: Yes/No:_____

If yes, texture (regular, chopped, soft, puree) or diet restrictions_____

Tastes Only: _____ **NOTHING** by mouth: _____

Position Student

▢ Sitting upright or semi-reclining ▢ Laying down ▢ Any position ▢ Other_____

Physician Name: _____ Phone: _____

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: _____

Reviewed by: _____ RN Date: _____