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) 567-8521

STUDENT'S NAME:_______________________________________ DOB: _____________

ALLERGIES:____

Treatments needed during school hours are (please indicate):

❑ Feeding by gravity--Syringe or Bag (circle one)

❑ Feeding by pump @ _____ml/hr

Procedure for feeding administration:

1. **Please specify diet** that will be given during school days:

   Name of Formula feeding:____

   Amount of feeding: ____

   Time(s) of feeding: ____

   *** Please give _________________of free water at (indicate time) ____AM and/or _____PM.

2. **Position Student**
   - ❑ Sitting upright or semi-reclining with head at ______degree angle -OR-
   - ❑ Lying on right side with head elevated at ______degree angle **-AND-**
   - ❑ Remain elevated for _________ minutes after feeding is administered.

3. **Flushing** - check one**:**
   - ❑ I DO order G-tube to be flushed after feeding with ____ml of free water
   - ❑ I DO NOT order g-tube to be flushed

4. **Does student have a Nissen?** Yes or No **Is it functioning? Yes or No**

5. **Comments:-**

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Physician's Signature ___________________________________ Date:_______________

Parent/Guardian Statement

❑ I, Parent/Guardian of ________________________, hereby request the School Nurse or trained staff member to administer the above procedure(s). I agree to furnish all equipment, formula or supplies necessary for the administration of the service/procedure listed above. **I 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: _____________________

Home phone: ______________________ Work: ____________________ Cell: _____________________

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Reviewed by: ____ RN Date: ____________________