SCHOOL DISTRICT OF HILLSBOROUGH COUNTY
SCHOOL HEALTH SERVICES

Physician's Orders for Gastrostomy Tube Feeding

DATE:	**RETURN TO:**
TO:	**SCHOOL:**
	ADDRESS:
PHONE # : **FAX # :**	**PHONE # :**
NAME:	**FAX # :**
D.O.B :	
PARENT / GUARDIAN:	

This form is being presented to you in order to request:

✓ **Physician's Orders for Medical Procedures (*Please specify under response*)**

________ **Medical Information: past ( ) / current ( ); an authorization signed by parent/guardian is attached.**

________ **Exchange of Information**

COMMENTS (to be completed by sender with assistance from Parent / Guardian)

We are requesting Physician's Orders to do Gastrostomy Tube Feedings at school as requested by the Parent. This includes administering medications, formula and water as needed. Please complete the Response/Order portion of this form and add any other information that you deem necessary to complete the order.

Response Requested: Yes ✓ No ________ Signature: ________________________________

Response/Order (To be completed by MD)

Diagnosis for which tube feeding will be required in school: ______________________________

Allergies: ________________________

Type of Gastrostomy appliance placed:

☐ PEG ☐ Button ☐ G-Tube ☐ Other (describe) ____________________

Tube feeding formula: ____

Amount of tube feeding: __________ cc

Tube flush: Amount of H2O tube flush: __________ cc

Frequency of feedings: ______________________

Tube feeding method:

☐ Bolus by gravity ☐ Bag ☐ Syringe

☐ Mechanical Pump - Type of pump ________________________ Rate of flow cc/hr. ______________

Are Oral Feedings permitted? ☐ Yes ☐ No If yes, please list the perimeters & consistency of these feedings below.

Please add additional information below:

Physician's Signature: ____________________________________ **Date:** ____________________