TUBE FEEDINGS
DOCTOR'S ORDERS FOR SCHOOL YEAR

Student's Name: ___________________________________

Brand Name of Feeding: _____________________________ Amount: _____________

Time to be Started: ________________ Length of Time to Run: ________________

How Given: Gravity Flow: Yes______ No______

Pump: Yes______ No______

Flow set on Pump: _______________

Check for Residual, If more than _______c.c.'s hold feeding and contact:

Parent______ MD______

Flush with __________ c.c.'s of water

Type Student Has: Foley______ Bard Button______ J Tube______

Mic Tube______ Mic Button______

Measures to be taken if tube/button comes out:

Replace with: ____________________ Size: ________

Cover with sterile dressing and send home immediately ________

Oral Feedings: Yes______ No______

If yes, texture and quantity of food ______________________________________

Parent will supply all materials for the feeding. Additionally an extra tube/button should be kept at the school in case of accidental dislodging.

Tastes of food only for oral stimulation: Yes______ No______

NPO: Yes______ No______

Suction if necessary: Yes______ No______

Chest Therapy: Yes______ No______ If yes: PRN______ or Q.D.______

Doctor's Signature: ________________________________

Date: ____________________

7/04