Office of Student Health Services
Chesterfield County Public Schools

Order for Tube Feeding Management at School

Healthcare Plan/Orders effective for current school year, including summer school.

Revised 7/2025

DOB: _____ **Grade:** _____

Student Name: _____ **School:** _____

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner):

Health Status

Diagnosis:

ICD 10: _____

Type of Tube ***(check one):*** ☐ **G-tube** ☐ **J-tube** ☐ **G-J tube** ☐ **NG tube**

Brand: _____ Size: _____

Surgical Date: _____ Balloon volume _____ mL ☐ Not Applicable

Feeding Method and School Schedule:

Bolus Feedings/Flush ***(check one)*****:** ☐ **Bolus/Syringe Method** ☐ **Slow Drip/Gravity-Bag Method**

☐ **Continuous Feedings:**

Type of formula/water _____ Volume to feed/flush _____

Frequency at school _____

Please indicate all that apply: ***(** LHCP must give specific instructions)***

Type of pump _____ Type of formula _____

Volume to feed _____ Frequency at school _____

Pump Rate _____

☐ * Position the student as follows during feeding: **_____

☐ After feeding, flush tube with _____ mL of room temperature water

☐ * Vent G-tube as follows: **_____

☐ Give flush of _____ mL room temperature water via G-tube _____ times per day

☐ * Check residual levels with parameters indicated: **_____

☐ Give medication as ordered via G-tube, followed by _____ mL of water to flush the G-tube

☐ If feeding pump is not working properly, then administer feeding via slow-drip/gravity bag method

☐ If feeding pump is not working properly, then administer feeding via bolus/syringe method

☐ If feeding pump is not working properly, then contact parent/guardian to come and administer feeding

☐ Other: _____

Replace Extender Tubing:
☐ Weekly
☐ Every 2 Weeks
☐ Monthly
☐ Other _____

Replace Feeding Bags:
☐ Daily
☐ Twice a Week
☐ Weekly
☐ Every 2 Weeks
☐ Other _____

If tube becomes dislodged:

☐ Notify parent and cover gastric site with dry dressing or bandage ☐ Ostomy tube needs to be IMMEDIATELY replaced -- CALL 911

☐ Licensed nurse (RN/LPN) may replace if nurse is immediately available on site; if nurse is trained; if supplies are provided by parent**

*** If resistance is met, parent will be notified and no further insertion attempts will be made.*

Other Specific Considerations: _____

Student Name: _____ **DOB:** _____ **Grade:** _____

School: _____

Physician Names and Phone Numbers

Primary Physician	**Phone Number**
Gastroenerologist	**Phone Number**
Other	**Phone Number**

This document must be completed in addition to the Individualized Healthcare Plan – General

Licensed Healthcare Provider

Licensed Healthcare Provider Name (Print) / Signature	**NPI#**	**Phone Number**	**Date**

To be Reviewed and Signed by PARENT/GUARDIAN:

☐ **I have reviewed and agree to this health plan for my student and understand that school staff /school nurse may communicate with my child's Licensed Healthcare Provider (LHP) regarding this health plan. I acknowledge that I am responsible for providing the school with all medications and supplies required to implement the plan as ordered by the LHP.**

Parent/Guardian Name (Print)	**Parent/Guardian (Signature)**	**Date**	**Phone Number**

School Nurse Name/Signature	**Date Received**	**Date Emergency Action Plan Distributed**