BALTIMORE LAB SCHOOL
THE DIFFERENCE IS EXTRAORDINARY

# PHYSICIAN ORDER FOR GASTROSTOMY TUBE FEEDING PROCEDURE

**This order is valid only for school year (current) _____ including the summer session**
This form must be completed fully in order to administer the tube feeding. A new administration form must be completed at the beginning of each school year, and each time there are any changes.

**Prescriber's Authorization**

Name of Student: _____Date of Birth: _____

**Procedure for Feeding**:

Name of Formula: _____ Volume to be given: _____mL

Method: □ Pump ☐ Gravity ☐ Syringe Flow Rate: _____mL/hr Device: □Button □PEG/Tube

Check for Aspirate: □ Yes □ No If Aspirate is greater than ____mL □ Feed □ Do NOT Feed

Flush before feeding or medication: _____mL water Flush after feeding or medication: _____mL

Feeding time(s) _____, _____, _____ Start date: _____ End date: _____

Position during feeding: _____ Position after feeding:_____

Medications*: □ Yes □ No Medication to be given: □ before feeding □ after feeding □ N/A
*Prescription Medication Authorization Form must be completed separately

Other instructions: _____

Prescriber's Name/Title:_____
Telephone: _____FAX: _____
Address: _____
_____

**Prescriber's Signature**: _____Date:_____
(Original signature or signature stamp ONLY)

## PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the tube feeding as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of tube feedings at school. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.
Parent/Guardian Signature: _____Date: _____
Cell Phone: _____ Work Phone: _____ Other: _____

School RN approval for self-carry/self-administration of emergency medication:
School RN Signature: _____Date:_____

Order reviewed by the School RN: _____
Signature/ Date