

Bedford County Public Schools

Tube Feeding Action Plan/Healthcare Provider Order

Student Information: Parent/Guardian to Complete

Student Name: _____ Grade: _____

DOB: _____ Age: _____ ID #: _____ School: _____

Order Requirements:

1. A new Healthcare Provider order is required for each school year and when a change has been made to the procedure.
2. Staff will complete the *Individual Feeding Log* after each feeding.
3. Parent/Guardian provides all supplies including an extra supply of formula to be kept in case of spillage/shelter in place.
4. Parent/Guardian may want to leave extra feeding extension tube and syringe at school.
5. If tube comes out, the parent/guardian will be called. BCPS staff WILL NOT reinsert it.
6. Parent/Guardian will give instructions and demonstration prior to first feeding in school.

Tube Feeding Order: Licensed Healthcare Provider to Complete

Student's condition requiring tube feedings:

Type of Tube: G Tube GJ Tube NG Tube J Tube **Method of Feeding:** Pump Gravity Push

Tube Feeding Schedule During School Hours:

Time	Formula/Liquid Name (include free water)	Amount (Quantity to be fed in mL's)	Rate/Duration of Feeding	Flush BEFORE Feeding or Medication	Flush AFTER Feeding or Medication
				_____ mL water <input type="checkbox"/> N/A	_____ mL water <input type="checkbox"/> N/A
				_____ mL water <input type="checkbox"/> N/A	_____ mL water <input type="checkbox"/> N/A
				_____ mL water <input type="checkbox"/> N/A	_____ mL water <input type="checkbox"/> N/A

Formula/Liquid: May substitute formula provided by parent Yes No

Student Position: Student should be fed sitting upright or semi-reclining & should remain upright for _____ minutes after feeding.

Venting Required: No Yes Frequency: _____

Residual Checks Before Feeding: No Yes

- HOLD FEEDING if residual is more than _____ mL
- Subtract residual volume from feeding volume if residual is between _____ - _____ mL

Pump Unavailable: In the event that the pump is unavailable (ie. malfunction, lack of equipment, etc.), bolus feeding may be given.

Medication to be Mixed/Given with Feeding: No Yes: See *Authorization for Medication Administration Form*

Oral Feedings: Does the student require oral feedings in addition to tube feedings? No Yes

- If yes, please specify what can be consumed, consistency, amount, and feeding precautions:

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Healthcare Provider Signature: _____ **Date:** _____

Healthcare Provider Printed Name/Stamp: _____

Healthcare Provider Phone #: _____ **NPI #:** _____

Healthcare Provider Address: _____

Parent/Guardian Authorization

My signature gives permission for the principal's designee to follow this plan, administer the feeding, and contact the healthcare provider if necessary. I also agree to pick up any unused supplies/formula at the end of the school year. I understand that supplies/formula not picked at the end of the school year will be discarded.

Parent/Guardian Signature: _____ **Date:** _____

Supplies/Formula Received	Supplies/Formula Picked Up
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Date: _____	Date: _____
Staff Initials: _____ Parent/Guardian Initials: _____	Staff Initials: _____ Parent/Guardian Initials: _____