Stark County Board of Developmental Disabilities

# Tube Feeding Orders

**Student's Name:** _____ **Date of Birth:** _____

**Address:** _____

**Phone:** _____ **Physician:** _____

I acknowledge that the above named student will be attending a center-based program and will require g-tube feedings during program hours.

**Please Specify**: Fill balloon with _____ml of water

**Type of device**: ☐ Gastrostomy (foley) Size _____ ☐ Peg Size _____ ☐ Mini button Size _____

☐ Jejunostomy Size _____ ☐ Mic-Key Size _____

**Type of Formula**: _____

Time _____ Amount _____ Rate _____

**Method of Administration:**

☐ infusion pump

☐ continuous

☐ bolus

Flush**: Solution** _____ **Amount** _____ **Frequency** _____

**Student is:**

☐ NPO at all times

☐ may receive fluids by mouth

☐ may receive oral feeding

☐ may participate in swimming classes

Please specify consistency, texture and any special instruction for any oral feeding.

_____

_____

_____

**Starting Date**: _____ **Termination Date**: _____

_____/ _____ **NPI #** _____

Physician's Name (Print Signature (No Stamps)

Date _____ Office Phone Number _____

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**TO BE COMPLETED BY PARENT/GUARDIAN**

I hereby give the personnel of the Stark County Board of DD permission to replace a dislodged device and/or administer the above G-Tube feeding to my son/daughter.

_____ _____

Parent/Guardian Signature Date