Central Kitsap School District
Health Services
PO Box 8, Silverdale, WA 98383
360-662-1070 / Fax 1-360-633-1688

Provider Order for Tube Feed at School

Student Name _____ DOB _____

School _____ Grade _____ School Year _____

TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER WITH PRESCRIPTIVE AUTHORITY

Type of tube _____ Size _____ Inflate _____ Placement date _____

Reason for treatment _____ Used for: ❑ Feeding ❑ Meds ❑ Both

Formula/nutrient _____

Can student eat/drink anything by mouth? ❑ Yes ❑ No If yes, what? _____

Is student on a pump? ❑ Yes ❑ No If yes, what type? _____ Rate _____ ml/hr

If on pump, can staff disconnect feeding for therapies and toileting? ❑ Yes ❑ No

Bolus? ❑ Yes ❑ No Amount _____ Frequency _____

Aspirate residual before feeding? ❑ Yes ❑ No If yes, return residual if less than _____ml

Vent before feedings? ❑ Yes ❑ No If yes, for how long? _____ minutes

Flush with water after each feeding? ❑ Yes ❑ No If yes, amount? _____ ml

How is feeding usually tolerated? ❑ Good ❑ Poor Position needed for feeding? _____

Position needed after feeding? _____ For how long? _____

If tube is displaced at school ❑ Parent/guardian has been trained to replace the tube

❑ Child must see doctor/surgeon to replace the tube

Hold feed if _____

Other instructions _____

Duration of order is for current school year unless otherwise noted _____

Provider's Signature _____ Date _____

Printed Name _____ Phone _____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

As the parent/legal guardian of this child, I request this treatment be provided as written and I understand that:

- Tubes that become dislodged or fall out cannot be replaced by school staff.
- This treatment will not begin until adequate training of qualified staff is completed.
- I must provide all necessary supplies and equipment to perform this service.
- I must notify the school about any changes or cancellations.
- Any supplies left at school after the end of the school year will be discarded.
- The school accepts no liability for untoward reactions when the treatment is administered in accordance with directions.
- My signature allows the school nurse to discuss this medical condition/order with the provider.

Parent/Legal Guardian Signature _____ Date _____

Printed Name _____ Phone _____