Tube Feeding - Nutrition Information

Student Last Name	Student First Name	Birthdate	Gender	Allergies
			☐ Male ☐ Female	

Parent/Guardian Name	Parent / Guardian Phone Number

Physician Name	Physician Phone Number

Type of Feeding Tube: ☐ **G-tube** ☐ **J-tube**

GASTROSTOMY OR GASTROJEJUNOSTOMY TUBE FEEDING

Time to Administer	Type of formula, juice, water	Amount / ml	Rate to Feed ml/hr or bolus

Student positioning during feeding:

Oral feedings

☐ **yes** (fill out Nutrition Information—oral feeding form)

☐ **no**

This is to certify that the above-named student is under my care and needs to receive gastrostomy or gastrojejunostomy tube feedings during school hours as ordered above.

Physician Signature________________ **Printed Name**____________________ **Date** _________________

Parent/Guardian Signature

I hereby request and give my permission for MDS nurse to administer the above-stated tube feeding to my child. I agree to submit a revised nutrition information form if anything changes and annually as required. I understand I must provide all the necessary equipment, supplies, and formula for my child's tube feeding.

Parent/Guardian Signature_________________________ **Print Name**__________________________
Date_______________