Prince William County Public Schools
Tube Feeding Health Treatment Plan

Student Name: ______________________ Date of Birth: ____________ Student ID: ____________

School/SY: ______________________ Date Received: ____________ Grade/Classroom: __________

Type of Tube:		Access at School:	Methods of Feeding:	Type of Nourishment:
☐ G-Tube	☐ GJ-Tube	☐ Yes	☐ Pump	☐ Formula: __________________
☐ NG-Tube	☐ J-Tube	☐ No	☐ Gravity	☐ Pureed Food: _______________
☐ Other __________			☐ Push	☐ Other: ____________________
☐ Size: ___________			☐ No access at school	☐ No access at school

If a tube comes out, the parent/guardian will be notified.
Prince William County Public School Staff WILL NOT reinsert the tube.

Order Requirements:

- A new healthcare provider order is required for each school year.
- Staff will complete the Individual Feeding Log after each feeding.
- Parent/guardian will provide extra formula/pureed food to be kept in case of spillage.
- Parent/guardian is responsible for preparing food (pureeing, straining, chopping, dicing, etc.).
- Parent/guardian will give a demonstration prior to first feeding in school.

Feedings:

Venting Needed: □ Yes □ No

Frequency: ____________Residual Checks: □Yes□ No

HOLD FEEDING if the residual is more than __________ml.

Subtract residual volume from feeding volume if residual is between ______ - _____ ml.

1st Feeding:

Time: _________Amount: ___________Rate: __________Flush ________ml water after feeding.

2nd Feeding:

Time: _________Amount: ___________Rate: __________Flush ________ml water after feeding.

PRN (as needed) Feeding:

Time: _________Amount: ___________Rate: __________Flush ________ml water after feeding.

Water to be given between feedings: □ Yes □ No

Time(s): _______________________ Amount: ________________

Signatures:

Healthcare Provider Name: ____ Phone#: __________________

Healthcare Provider Signature: ____________________________________ Date: __________________

School Nurse Signature: ____ Date: __________________

I approve and give permission for school personnel to follow this plan, which may include administering medications according to the healthcare providers' orders. I assume full responsibility for providing the school with prescribed medication and supplies.

Parent/Guardian Signature: ____ Date: __________________