

Clarksville-Montgomery County School System

HEALTH SERVICES

PARENT/GUARDIAN INPUT – FEEDING TUBE MANAGEMENT

School Year 20____ - 20____

Student's Name: _____ DOB: _____

Parent(s)/Guardian Name: _____

Contact number(s): _____

Parent(s)/Guardian contact phone number(s) during school hours

Physician's Name: _____ Phone: _____

My child has a feeding tube due to _____

The feeding tube has been in place since he/she was _____ years old.

Type of feeding tube: _____

Check items below that apply to your child and provide necessary information along with the physician orders (HEA-F045 - Physician's Orders for Feeding).

____ My child is unable to take liquids and/or food by mouth.

____ My child is able to take liquids and/or food by mouth. Types of liquid and food child may take by mouth include: _____

____ Child is able to manage some aspects of care and use of his/her feeding tube, but will need assistance with the following: _____

____ Child is able to manage care and use of his/her feeding tube independently.

Routine care and use of feeding tube during school hours include:

Check all that apply and provide information and physician orders (HEA-F045- Physician's Orders for Feeding).

____ Type of formula or feeding _____

____ Temperature of formula or feeding _____

____ Amount per feeding _____

____ Frequency or time of feeding(s) _____

____ Feeding tube to be flushed with _____ (amount) of water before and after feeding.

____ Position during feeding _____

____ Skin Care _____

____ Other instructions/comments _____

Instructions for potential feeding tube complications:

Please put a star (*) next to item if it has occurred within the last year.

____ Plugged tube _____

____ Feeding tube out (pulled or fell) _____

____ Other _____

Parent/Guardian Signature _____ Date _____