



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 (smaller font)

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 _____