KNOX COUNTY SCHOOLS
ANDREW JOHNSON BUILDING

HEALTH SERVICES

MEDICAL ORDER: GASTROSTOMY/JEJUNOSTOMY TUBE FEEDINGS

Student Name: _____ Date of Birth: _____

Please provide orders regarding the above student's gastrostomy and/or jejunostomy feeding tube; to include management of gastrostomy/Jejunostomy tubes. Students with a feeding tube that require oral feedings must have a medical order. **School Nurses do not replace MIC Tubes/Buttons.**

Medical Diagnosis:

_____

_____

_____

Type of Tube: _____ Gastrostomy _____ Jejunostomy _____ Naso-gastric

Feeding Orders:

1. Formula _____
2. Amount _____
3. Time _____
4. H20 Flush Amount _____

_____ Gravity/Bolus (over 30 minute's) _____ Pump Rate: _____

Site Care:

1. Routine site care _____
2. Clogged tube _____
3. Dislodged tube _____
4. Follow Management of Gastrostomy/Jejunostomy Tube Protocol _____
5. Insert 8FR Foley Cath (bulb deflated) _____

Additional Orders:

_____

_____

_____

Health Care Provider Signature: _____ Date: _____

Health Care Provider Address: _____

Phone: _____ Fax Number: _____

Parent Signature: _____ Date: _____

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