Physician Order for Gastrostomy Button Feeding

Name of Student:____ Birth Date:__________________

1. The above student is being treated for:__________________________________

2. Name of procedure: **Gastrostomy Button Feeding**

   The parent is required to provide the necessary supplies.

3. Procedure Information:

   A. ___________________________________Formula/feeding (type of feeding)

   ___________________________________cc's (amount)

   B. May be flushed with __________ cc's water before feeding

   C. May be flushed with __________ cc's water after feeding.

   D. Feeding time ordered ________________(time)

   E. Feeding to be completed in __________________ minutes.

   F. Position for feeding ________________.

   G. May/ May Not have food/liquid by mouth also (Circle One)

4. The procedure is to be continued as above until:__________.
   Date

All authorizations expire at the end of the current school year.

5. This procedure MUST be performed by licensed personnel ONLY. Yes___No___
   Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.

Note: RN may need to contact physician in writing or by phone.

This procedure will be performed according to KISD protocol unless otherwise specified by physicians' written order.

Physician's Signature:_________________________ Date:____________________

Print Physician's Name:________________________ Phone:___________________

Parent permission: I hereby request that the treatment specified above be performed to the above-name child. I give permission for the RN to contact the physician in writing or by phone.

___________________________	___________________	________________
Signature of Parent/Guardian	Phone	Date