

Please return to Nurses’ Office

**2023-2024**





1143 Delsea Drive • Westville NJ 08093 • Phone: 856-812-6030 • Website: adsschool.org

**N8 Enteral (GT) Feeding Orders 2025-2026**

A written order for medical treatment that your child requires during the school day (9:00 am to 2:30 pm) must be on file in the nurse's office. **STUDENTS MAY NOT SELF MEDICATE.**

**Student Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastronomy/Jejunostomy Type of GT: \_\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of formula** | **GT** | **Volume (ml) and rate (ml/hr)** | **Time**  **to administer** |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medications** | **Dosage** | **Route (PO, GT)** | **Time to administer** | **Reason for medication** |
|  |  |  |  |  |

Does a pump deliver feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oral feedings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vent GT before feeding: Yes \_\_\_\_\_ No \_\_\_\_\_ Duration? \_\_\_\_\_\_\_\_\_ minutes

Aspirate residual before feedings? Yes \_\_\_\_No \_\_\_\_\_ Discard \_\_\_ Return to stomach \_\_\_\_\_\_\_\_\_\_\_\_

Is feeding tolerated well? If no, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Physician’s Signature)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Physician’s Name printed) (Physician’s Address/ Phone number)**

\_\_**X**\_\_\_ I give permission for my child to receive medical treatment during school hours as prescribed by a physician.

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_

Received\_\_\_\_\_\_\_\_\_\_\_\_ Scan to Realtime\_\_\_\_\_\_\_ Original to MAR binder\_\_\_\_\_\_\_\_\_