Student Name: _____ Teacher: _____ Grade: ____ School: _____ Sch. Yr.:_____
(last) (first)

Student ID#: _____ DOB: _____ HCP name: _____ PH:_____

Parent/Guardian Contact Information (indicate priority to call):

Mother: #___
_____ Cell: _____ Work: _____

Father: # ___
_____ Cell: _____ Work: _____

Other: # ___
_____ Cell: _____ Work: _____

Date: _____

Tube Feeding Schedule: **2 Hour Delay:**

Time: _____ **Feeding Solution:** _____ cc/minute **Time:** _____
Time: _____ **Feeding Solution:** _____ cc/minute **Time:** _____
Time: _____ **Feeding Solution:** _____ cc/minute **Time:** _____

Pickerington Local School District

TUBE FEEDING LOG SHEET

Type of Tube:	◯ Gastrostomy Mic-Key Button	◯ Triple Port Replacement G –Tube	◯ Jejunal Feeding Tube	◯ Percutancous Endoscopic Gastrostomy (PEG) Tube		
Tube location:	◯ Right Upper Quadrant	◯ Left Upper Quadrant	◯ Right Lower Quadrant	◯ Left Lower Quadrant	◯ Other:	
Method of Feeding:	◯ Gravity – drip	◯ Pump	◯ Syringe			

		Date:																	
		Time:																	
Observations	Tube Site	Intact																	
		Blocked																	
		Fell Out																	
	Skin Integrity	Intact																	
		Red																	
		Drainage @ site (describe)																	
		Other:																	
		Amount of Residual																	
	Symptoms	Nausea																	
		Cramping																	
		Vomiting																	
		Cough																	
		Breathing Difficulties																	
		Change in skin color																	
		Other:																	
Fluid/Formula Intake		Fluids:																	
		Oz. _____																	
		Fluids:																	
		Oz. _____																	
		Fluids:																	
		Oz. _____																	
		Fluids:																	
		Oz._____																	
		Other:																	
Student Outcome		Resumed class																	
		Return to Recess																	
		See note on back/computer																	
		School Nurse notified																	
		Called parent/guardian																	
		Note sent home																	
		Call 911																	
		SCHOOL STAFF INITIALS																	

Student Name: _____ Teacher: _____ Grade: ____ School: _____ Sch.Yr.:_____
(last) (first)

Narrative Notes

Date	Notes/Signature

School Staff Providing Care

Initials	Signature	Title

Request for Supplies

Date	Time	Supply	Initials