Health Services

G-Tube Feeding Flow Sheet

Name: ____ **DOB:** ____ **Student ID#:** ____

Campus: ____ **Grade:** ____

	TIME			RESIDUAL				FEEDING	WATER	GAGGING		WEIGHT		
DATE				YES	NO	AMOUNT	Return to Stomach Yes	Blenderized Formula Amount	Ounces To Flush Tube	Yes	No	LB.	KG.	NURSING NOTES

Initial Signature Initial Signature Initial Signature

BISD Form I B-3, 6/09