MT. VERNON COMMUNITY SCHOOL CORPORATION

MANAGEMENT PLAN FOR GASTROSTOMY and/or JEJUNOSTOMY TUBE

Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP) / Extracurricular Plan / Bus Plan

SECTION I –PARENT (Please, Print) **IEP?** ❑ YES ❑ NO **504?** ❑ YES ❑ NO

Student Name: _____ DOB: _____ Teacher/Grade: _____

Student Home Address: _____

Known Allergies/Triggers: _____ WT _____ HT _____

Medications Taken at Home: _____

Potential Side-Effects of Home Meds: _____

Bus Transportation ❑ YES ❑ NO Bus # a.m. _____ Bus # p.m. _____ Fieldtrip/Extracurricular Bus Transportation ❑ YES ❑ NO

Parent/Guardian Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Parent/Guardian Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone#: _____ Fax#: _____

Physician Address: _____ Preferred Hospital: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II – PHYSICIAN: (Please, Print)

***A signed Parent Authorization (PPA) form is required for each medication. ***

Is a medication PRESCRIBER/PARENT AUTHORIZATION (PPA) on file for this student? ❑ YES ❑ NO Medication given per g-tube/j-tube? ❑ YES ❑ NO

If student "self-carries" medication, a "back up" medication may be kept in clinic? ❑ YES ❑ NO

Date of Gastrostomy and/or Jejunostomy Placement _____ ***The stoma is considered a mature site 6-8 weeks post op.***

Feeding Tube (check one): ❑ Gastrostomy ❑ Jejunum ❑ Gastrostomy/Jejunum

Type of G-Tube/J-Tube: ❑ Mic-Key ❑ Bard Button ❑ Foley ❑ Other

Lumen Size: (Fr.) _____ Length: _____ Balloon Size: _____

Position During Feeding: _____ Type of Formula: _____

Bolus ❑ YES ❑ NO Feeding Times:						
Continuous ❑ YES ❑ NO Amount (ml):						

SPECIAL INSTRUCTIONS:

Continuous Feeding formula to be changed every_____ hrs. Site to be secured with band or ACE wrap: ❑ YES ❑ NO

Rinse bag with warm water to remove all residue before refilling:

Check Placement: ❑ YES ❑ NO Check Residual: ❑ YES ❑ NO Amount (ml): _____

Flush Before Feeding: ❑ YES ❑ NO Solution to be used: _____ Amount (ml): _____

Flush After Feeding: ❑ YES ❑ NO Solution to be used: _____ Amount (ml): _____

Feeding Tube Supplies will be: (Check One) ❑ Left at School ❑ Transported between home and school daily

EMERGENCY ACTION PLAN (EAP)

***Replacement tube to be kept at school in the event of an emergency.**

☐ The school nurse ***should attempt*** to replace the g-tube should it become dislodged at school. Should tube not be able to be reinserted, cover with clean gauze and notify parent immediately. Instructions for replacement are to be provided by the healthcare provider along with this order.

☐ The school nurse ***should not*** attempt to replace the g-tube should it become dislodged. The stoma should be covered with clean gauze and the parent notified immediately.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital, in the event of an emergency and for the release of my child's medical information to be shared with appropriate persons on an as-needed basis to insure the health and safety of my child. A nurse will not be present on the school bus, private car, or extracurricular activity.

Physician Signature **Date** Parent Signature Date Student Signature Date Nurse Signature Date

FOR SCHOOL NURSE USE ONLY

Medication/Supplies	Self-Carry?	Self-Administer?	Expiration	Location of Medication