



Picture

G-Tube Feeding Plan

Student _____ Grade _____ Date _____

Date of Birth _____ School _____ Teacher _____

Address _____ Parent/Guardian _____

City _____ Zip Code _____ Home Phone _____

Emergency Contacts

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name of formula: _____

Formula administered via:

- Pump
- Syringe
- Gravity

Type of pump: _____

Volume to be given: _____ ml (milliliters) over _____ minutes

Amount of flush: _____ ml flushing instructions: _____

Feeding times: _____

Position during feeding _____

Position after feeding _____

Note to Health Care Provider/Parent/Guardian:

- The parent/guardian will be notified if a tube becomes clogged or dislodged. *See emergency protocols on next page.*
- School personnel cannot forcefully flush or replace a feeding tube in the stomach.
- Feeding formula must be sent to school in the original unopened container.

Additional Health Care Provider's comments: _____



G-Tube Emergency Protocol

If G-Tube would fall out:

- Call parent immediately
- Put on gloves
- Cover site with gauze and tape
- Place student in upright position
- Observe student for loss of gastric contents
- Observe student for signs of shock
- If student is in distress call 911
- Do NOT attempt to replace G-Tube
- Call School Nurse to report incident
- Document incident

Parent Consent For Management Of Health Condition While At School Or Other School Related Activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date _____

Physician Information

Print Name of Provider _____ Clinic Name _____

Phone Number _____ Fax Number _____

Address _____

Signature of Provider _____ Date _____