GASTROSTOMY/JEJUNOSTOMY CARE PLAN

HEALTH SERVICES
SCHOOL DISTRICT U-46

School Year: Choose year Grade/Teacher:

Student Name:_____ID#: _____Birthdate: _____

Address: _____IL_____

PARENTS PLEASE COMPLETE THE FOLLOWING INFORMATION:

Parent/Guardian Name: _____

Home Phone: _____

Mom Cell Phone: _____Mom Work Phone: _____

Dad Cell Phone: _____Dad Work Phone: _____

Primary Physician Name: _____

Medical Group: _____ Phone:_____

Specialty Physician Name: _____

Medical Group: _____ Phone:_____

Diagnosis: _____ Age or year of diagnosis _____

Does your child require gastrostomy/jejunostomy feedings at school? ☐No ☐Yes

Does your child's gastrostomy/jejunostomy need to be vented? ☐No ☐Yes If Yes explain: _____

I understand that it is my responsibility to keep my child's school personnel informed of changes in my child's medical condition and to immediately notify them and complete a new form if treatment for the condition is changed or modified in any way. I understand information is to be updated annually with each school year.
I give permission for the nurse to communicate as warranted with the physician regarding my child's health concerns. I give permission for above named student to be gastrostomy tube fed at school.

Parent/Guardian Signature:_____Date:_____

To be completed by student's physician:

Feeding:

- ✓ Method to be used for checking proper tube placement: _____
- ✓ Student's position during feeding: _____
- ✓ Formula: _____
- ✓ Amount of Formula: _____
- ✓ Rate of infusion: _____
- ✓ Frequency of Feeding:_____
- ✓ Amount of water to be infused after feeding: _____
- ✓ Hold feeding if:_____
- ✓ In the event tubing becomes clogged:_____
- ✓ Other instructions:_____

Physician Signature: _____Date:_____

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Fax Number:_____

School Nurse Signature:_____Date:_____