Fife School District Special Services

G-Tube / J-Tube

Confidential Information

MEDICAL Treatment Care PLAN

2025-26 School Year

Photo

TREATMENT ORDERS

Name:	School:	Grade:	Birth Date:

EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:

Licensed Health Professional's G-Tube Procedure Request at School

To Be Completed by a Licensed Health Professional with Prescriptive Authority

Type of Gastrostomy Tube:_____ Size:_____ Inflate_____ cc Date of Replacement:_____

Reason for Treatment:_____ G-Tube used for ☐ Feeding ☐ Medication ☐ Both

Type of formula/nutrient_____

_____Time(s) of feeding(s): _____and ☐ PRN

Can student eat/drink anything by mouth? ☐ YES ☐ NO If YES, what?_____

Is student on a pump? ☐ YES ☐ NO If YES, what type?_____ Run at:_____ □ml/hr

If student feeding requires pump, school staff may disconnect feeding for therapies and diapering/toileting? ☐YES ☐NO

Aspirate residual before feeding? ☐ YES ☐ NO If YES, return residual if less than ml

Vent before feedings? ☐ YES ☐ NO If YES, for how long?_____ Minute(s)

Flush with water after each feeding? ☐ YES ☐ NO If yes, amount_____ ml

How is feeding usually tolerated? ☐ Good ☐ Poor Position needed for feeding:_____

Position needed after feeding:_____

IF G-tube is displaced at school: *Check all applicable*:

☐ Parent and/or legal guardian has been trained to replace g-tube

☐ Child must see their doctor or surgeon for reinsertion of the g-tube

Hold feedings if: _____

Other instructions:_____

Duration of order(s): ☐ School Year ☐ (mm/dd/yr)_____ to_____.

Licensed **H**ealth **C**are **P**rovider's Signature: (and health plan team member)	Date:	
LHCP's Printed Name:	Phone :	Fax Number:

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

To Be Completed by the Parent or Legal Guardian

I request that the school nurse or designated staff member be permitted to administer to my child, (name of child),_____ _____the treatment prescribed by (name of health care provider) _____for the school year ending June_____ (year). I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded. I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed
- I understand that I must provide all necessary supplies and equipment to perform this service.

G-Tubes that become dislodged or fall out: Please be aware that school staff do not have universal training to replace G-tubes.

_____ _____

Parent/Guardian Signature Date

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Individual health ACCOMMODATION PLAN for School

Name:	School:	Grade:	Birth Date:

ACTION PLAN

IF YOU SEE THIS	DO THIS
Serious Complications: Turns bluish or pale/ashen or has difficulty breathing Sudden distention or sign of left upper quadrant or epigastric pain Agitation, distress, distention and vomiting	Stop feeding immediately. Call for the school nurse at: . If he/she is not present, **Notify 911** ,parent/guardian, building administrator and stay with the student. **Give: Medical plan** to the medical responders.
Nausea and/or cramping	Stop feeding, let feeding get to room temperature, then administer.
Vomiting	Stop Feeding. Turn student to their left side and clean our mouth. Call school nurse and parent/guardian.
Blocked tube or device	Flush with warm water. If blockage remains call school nurse or parent/guardian.
Bleeding/drainage/redness/irritation Leaking of stomach contents	Clean stoma site if leaked food, fluid, or medication come in contact with the skin. Turn device in a complete circle with each cleaning. Dry stoma well, open to air to facilitate drying. Notify school nurse and/or parent/guardian.
Gastrostomy tube/device falls/is pulled out	Clean skin and notify school nurse and/or parent. **This is not an emergency!** Put tube/device in a clean plastic bag for reinsertion. Cover site with a clean gauze pad. Contact school nurse or parent/guardian. **Do not attempt to replace tube.**
Other accommodations as deemed appropriate:	

- I understand this treatment may be given by **designated staff** that are **t**rained and supervised.
- I give Health Services Staff permission **to communicate with the medical office** about this treatment.
- Medical/Treatment **information may be shared with school staff** working with my child and 911 staff, if they are called.
- Team members agree this treatment **substantially impairs** a major life activity and is **eligible** for Section 504.
- **Various sources of information were considered**: Medical information from LHCP, Parent, Nurse and academic setting.

Parent/Guardian, health Team Member:_____ Date:_____

School Nurse, health Team Member: _____ Date:_____

The information from this plan will be shared with: Parent, Teacher(s), Principal, Office Staff, Transportation, and Food Service. Other: (Elementary: Specialists and Recess Personnel) (Coaches when applicable).

If sent electronically to school staff, signed original is kept: in Health Room. (Rev 3/17/15)