

IHP/EAP for Student with Tube Feeding

Student Name: _____ DOB: _____

Parent/Guardian _____

Phone (h) _____ (w) _____ (c) _____

Healthcare Provider: _____ Phone _____

Medical History/ Diagnoses:

Date tube placed: _____

Brand/type of device: _____

Size: _____ fr _____ cm

Medications:

At home: _____

At school: _____

Guidelines:

- ☐ Do NOT give any foods or liquids orally
- ☐ Able to eat and drink by mouth
- ☐ Able to eat solids by mouth but do not give any liquids by mouth
- ☐ Other: _____

If oral feedings are allowed, what foods or liquids are to be given at school:

Feeding Information:

Formula Type: _____

Feedings given at: _____

- _____ mL will be administered at each feeding
- _____ mL of water for flush
- Rate of feeding _____ mL/hr

- ☐ Pump bolus feed
- ☐ Slow drip or continuous feed
- ☐ Bag gravity feed

- ☐ Syringe gravity bolus feed
- ☐ Medication Administration
- ☐ Other: _____

Is it necessary to measure residual stomach contents? ☐ Yes ☐ No

If yes, please indicate the residual amount that would prohibit feeding at the scheduled time: _____ mL total volume

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Physician Consent for Student with a Tube Feeding IHP

I have reviewed and approved this management plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly.

☐ Nurse may replace G-button with proper training.

Training on G-button replacement will be provided by: _____

Other Comments: _____

Healthcare Provider Signature

Date

Parent Consent for Student with a Tube Feeding IHP

I, as parent/guardian, concur with the above management plan, and will provide the necessary supplies and equipment, notify the school nurse if there is any change in our child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

Parent/Guardian Signature

Date