



Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

G-tube Feeding Plan

Student _____ Date _____ Grade _____

Date of Birth _____ School _____ Teacher _____

Address _____ City _____ Zip Code _____

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 over _____ Minutes.

Amount of Flush: _____ mL **Flushing Instructions:** _____

Feeding Times: _____

Position during feeding: _____

Positing after feeding: _____

Additional Comments: _____

Note to Health care Provider/Parent/Guardian:

- The parent/guardian will be notified if a tube becomes clogged or dislodged. (see emergency protocol on next page).
- School Personnel cannot forcefully flush or replace a feeding tube in the stomach
- The feeding formula must be sent to school in original unopened container.

-OVER-

Student Name:_____ **Student DOB:**_____

G-Tube Emergency Protocol:

If G-Tube falls out:

- Call parent immediately
- Put on gloves
- Cover site with gauze and tape
- Place student in upright position
- Observe 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 _____

Provider NPI # _____

By signing this form you are acknowledging this medication/Health plan is medically necessary for school