

Gastrostomy Action Plan

Keller ISD Health Services Department

NAME: _____ DOB: _____ Teacher/Grade: _____

Emergency Contact #1: _____	Preferred Contact #: _____
Emergency Contact #2: _____	Preferred Contact #: _____
Physician Treating Condition: _____	Preferred Contact #: _____
Preferred Hospital: _____	

DIAGNOSIS/CONDITION: GASTROSTOMY

Type of G-Tube: _____

Insertion Date: _____

INSTRUCTIONS FOR FEEDING:

- Formula: _____
- Amount: _____
- Method of Administration: _____
- Equipment required (supplied by parent): _____
- Flushed with _____ cc water
- Frequency of feeding: _____
- Duration of feeding: _____
- Student Position: _____
- Cleaning Method: _____
- Residual: Yes ☐ No ☐ If yes, hold feeding if residual more than _____ cc's
- Precautions, unfavorable reactions: _____
- Disposition of student following procedure: _____
- Other pertinent information: _____

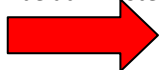
***If tube/button becomes dislodged, stoma will be covered with gauze and parent will be notified. Any other additional action? _____

MEDICATIONS TO BE ADMINISTERED DURING SCHOOL

(Medication Authorization form is required if administered during school):

Medication Name	Route	Dosage	Time

Following all applicable laws, rules and regulations, the prescribed procedure may be performed by the School Nurse, Licensed Vocational Nurse or trained unlicensed employee. The prescribed procedure required during the school day will be administered on receipt of this completed form, along with any special equipment items.



PHYSICIAN – Please complete above information and sign;

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____