20_____- 20_____

USD 261 HAYSVILLE SCHOOLS

G-Tube Care Plan in School Setting

Student Name	
DOB	
Grade/Teacher	

Parent/Guardian & Phone #	
Primary Care Dr & Phone #	
Specialist & Phone #	
Preferred Hospital:	
Emergency Contact	

Current Health Issues:	
Pertinent Health History:	Date g-tube placed: _____ Brand/type of device: _____ Size: _____ fr _____cm
Allergies:	
Restrictions:	☐ Do **NOT** give any food or liquids orally ☐ Able to eat and drink by mouth ☐ Able to eat solid foods by mouth but do **NOT** give any liquids by mouth ☐ Other: _____

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Current Medications:	At Home: _____ _____ At School: _____ _____
Health Problem (s):	
Problem: Inadequate Nutrition Intake	Basic Feeding Information: Formula type is: _____ Feeds will be given at: _____ ☐ _____mL will be administered at each feeding ☐ _____mL of water for flush ☐ Rate of feed (only if given by pump) _____mL/hr
Problem: Bleeding and/or drainage from g-tube site	☐ Check to be sure the tube is not being pulled on. ☐ Check that cap is in place ☐ Check for leaking at insertion site o If leaking or bleeding noted, notify RN and parents ☐ If needed, change g-tube dressing
Problem: Risk of g-tube stoma closure	If g-tube comes out, trained/delegated staff may: **G-tube is greater than 8 weeks old:** ☐ Rinse device with warm water or use replacement device provided by family and deflate balloon if necessary. ☐ If needed, wipe skin around site with a paper towel to dry prior to reinsertion. ☐ Apply lubricating jelly to the end of the device. ☐ GENTLY reinsert device into stoma opening. If using a foley catheter, insert foley, kink the tubing, and tape it to the skin. For a child that over the age of one year that has a G-tube or a GJ-tube you should insert the Foley catheter 2 inches.

Problem: Risk of g-tube stoma closure (cont.)	☐ If you meet resistance when attempting to reinsert, try next size down (if available). Do NOT force the replacement device into the stoma. ☐ Cover site with dry, sterile gauze and secure with tape. ☐ Notify parent and RN ☐ Do NOT inflate balloon for feed until checking for placement by: o Listen for Air o Aspirate residual stomach contents **G-tube is less than 8 weeks old (DO NOT REPLACE):** ☐ Notify parents and RN about dislodgement ☐ Cover site with gauze or paper towel to help with leaking. ☐ Parents will need to pick up student and take them to see provider for G-tube replacement prior to using the G-tube in the school setting. ☐ Check box if parent **does not** want the school to attempt replacement of G-tube. Staff will notify the parent immediately if the g-tube becomes dislodged and the parent will come and replace g-tube.
Problem: Potential problems with feeding tube.	Monitor for the following problems that may occur during feeding: ☐ Coughing, laughing, or crying during the feeding can cause the feeding or stomach contents to be forced back into the tubing. Clamp the tubing until the child stops the behavior and then proceed with the feeding. ☐ Nausea, cramping, discomfort, hiccoughs can be the result of the feeding being too fast, too cold, too hot, or the volume is too large. Stop the feeding and check the temperature of the feeding. Proceed if temperature is correct at a slower rate. If these symptoms persist with more than two feedings notify the school nurse. The volume of the feeding may need to be evaluated.

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Problem: Potential problems with feeding tube (cont.)	☐ Vomiting can be a result of any of the above problems. If vomiting occurs, stop the feeding. Notify the parents that the feeding was interrupted, how much food was given, and approximately how much they vomited. ☐ Blocked tube prevents the food/fluid from moving. The tube may have been clogged with dry or thick feeding. If this occurs do not try to flush tube or squeeze tube. Contact parent or school nurse immediately.

Physician Consent for G-Tube IHP

Medical Provider: Your signature serves as the medical order for this plan of care including medication administration as outlined on this care plan.

_____ _____

Physician Signature Date

Parent Consent for G-Tube IHP

I grant permission for Haysville Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary. I hereby request that Haysville schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Haysville Schools. I have reviewed the above statements and agree to abide by Haysville Schools School District Policy regarding the administration of medication/ procedures at school. I further release Haysville schools and school personnel from liability when my child self-carries and self-administers medication.

_____ _____

Parent/Guardian Signature Date

_____ _____

School Nurse Signature Date