INDIVIDUALIZED HEALTHCARE PLAN GASTROSTOMY TUBE

FRANKLIN COUNTY PUBLIC SCHOOLS

School Year: _____

Student Name: _____ DOB:_____

School: _____ Teacher: _____ Grade: _____

Allergies:_____

Parent/Guardian(s) Name: _____

Address: _____

Parent/Guardian to call 1st: Home: _____ Work: _____ Cell: _____

Parent/Guardian to call 2nd: Home _____ Work: _____ Cell: _____

Alternate contact person in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Physician Name: _____Phone:_____

HISTORY OF RECENT MEDICAL CONDITION:

_____

_____

TREATMENTS & MEDICATIONS NEEDED DURING SCHOOL HOURS ARE (please indicate & provide detail below):

☐ Feeding by gravity ☐ Feeding by pump ☐ Hygiene & Skin care

☐ G-tube medications – Please list drug, dosage and frequency: _____

_____

_____

_____

_____

TYPE OF G-TUBE:

☐ PEG ☐ MIC-Key Button ☐ Catheter ☐ Other: _____

SIZE: 12F 14F 15F 16F OTHER:_____ LENGTH OF TUBE:_____

VOLUME OF WATER IN THE BALLOON_____ML

PROCEDURE FOR FEEDING ADMINISTRATION:

1. Position student during & after:
   - ☐ Sitting upright or semi-reclining with head at ____ degree angle – OR-
   - ☐ Lying on right side with head elevated at _____ degree able –AND-
   - ☐ Remain elevated for _____ minutes after feeding is administered.

2. Aspirate – Check one
   - ☐ I DO order to check for aspirate

     If aspirate is greater than _____cc, ☐ feed ☐ DO NOT feed

     ___ Delay feeding for ___ minutes and repeat aspiration.
   - ☐ I DO NOT order to check for aspirate.

3. Flushing-Check one:
   ☐ I DO order G-tube to be flushed ☐ Before feeding or medication with ___cc water
   ☐ After feeding or medication with ____cc water
4. PLEASE SPECIFY DIET that will be given during school day:
   Type of feeding: _____ Amount: _____
   ***Please give _____ of free water at (indicate times) _____
5. Oral intake other than tube feeding (be specific):

   _____

   _____
6. Comments:

   _____

   _____
7. Special Activities:_____

   _____
8. Special Transportation Needs:_____

   _____

EMERGENCY PLAN:

IF YOU SEE THIS	**DO THIS**

ProviderSignanature:_____Date:_____

Parent/Guardian Statement

I give permission for _____ to receive the above medication(s)/ treatment(s) at school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication or supplies to enable the physician's orders to be followed. I also, give permission for this plan to be available for use in my child's school and for the nurse to contact the above named physician when necessary to carry out the plan.

Signature: _____ Date: _____