

# MANAGEMENT PLAN FOR GASTROSTOMY and/or JEJUNOSTOMY TUBE

## Individualized Healthcare Plan (IHP) / Emergency Action Plan (EAP)



Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: \_\_\_\_\_

*This form provides health care provider and parental authorization for medical treatment to be provided during school hours. Both the prescribing health care provider and the parent/legal guardian are required to complete this document before the services can be provided.*

**Note:** Physician's orders are required for all medical procedures administered at school. Please have your child's physician complete this portion of the form and return it to the school or have them fax it to the District Health Services or school nurse.

**The following section is to be completed by the prescribing physician or health care provider: The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that the prescribed treatment may be administered by trained non-medical personnel.**

Diagnosis for which tube feeding will be required in school:

Type of tube:

Type of formula:

Times of tube feedings:

Amount of formula:

Amount of water flush:

Tube feeding method:  Syringe bolus  Mechanical pump- rate of flow:

Side effects to be reported:

Clinic Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Name (Print): \_\_\_\_\_ Fax Number: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorize this procedure to be performed by the school nurse or the nurse's delegate as directed above. I agree to provide the needed supplies for the procedure and understand that new forms must be completed annually or with any changes in the student's health status.**

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_



## EMERGENCY ACTION PLAN (EAP) IF TUBE BECOMES DISLODGED

\*Replacement supplies are to be kept at school in the event of an emergency.

**Supplies are Located:** \_\_\_\_\_

-Water based lubricating jelly

-Tape

-Syringe

**Call the nurse immediately, the nurse will:**

1. Wash hands with soap and water
2. Use the dislodged g-tube if available and undamaged or new tube if available
3. Deflate balloon with syringe
4. Lubricate shaft with water soluble lubricant if available
5. Gently insert into gastrostomy site
6. DO NOT INFLATE THE BALLOON
7. Secure in place with medical tape
8. Call parent/guardian immediately

Clinic Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Provider's Name (Print): \_\_\_\_\_ Fax Number: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_