Muscogee County School District
Student Health Services
Gastrostomy and Jejunostomy Tube Student Health Care Plan

Please complete this health care plan and return to the school clinic.
A new health care plan is required every school year.

Student: ______________________ **Date of Birth:** ______________ **School year:** ______

School: ______________________ **Teacher:** ______________________ **Grade/Team:** _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Healthcare Provider:		**Phone Number:**	

Gastrostomy Tube Details:

Name of Tube: ____

Size of Tube: ____________ G/Fr Measurement at Skin: ____________ cm

Type of Tube:

- ☐ G-Tube/PEG
- ☐ J-Tube/PEJ

Low Profile Stomate:

- ☐ Yes
- ☐ No

Method of Feeding:

- ☐ Gravity drip
- ☐ Pump
- ☐ Syringe

Schedule of Feedings:

- ☐ Continuous
- ☐ Intermittent

Medication Administration

Most medications can be given via the feeding tube. It is recommended that:

- Liquid medication is used whenever possible (suspensions/elixirs).
- If a table must be crushed, be sure to crush it into a fine powder and mix it well in warm water.
- The tube is flushed with 20-30ml of warm water **BEFORE and AFTER** medication administration.
- If more than one medication is to be given, give each separately and flush the tube with 5 ml of warm water between medications.

Venting/Decompression
Abdominal discomfort and bloating may be caused by excessive air/gas in the stomach. Allowing air to escape (venting or decompression) should be performed prior to each feed or medication administration.

Positioning
Tube feeds must only be give when the client is sitting upright, standing, or half seated with the head raised 30 degrees or more. **Never lie flat during a feed, and wait for one hour after the feed before lying down.**

Comments and Special Instructions (including school activities, sports, field trips, etc):

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Physician's Authorization
My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ If changes are indicated, I will provide new written authorized orders
- ☐ Dose/treatment changes may be relayed through parent/guardian.

Physician's Signature: ______________________________ **Date:** ____________

Physician's Name: ______________________________ **Phone Number:** ____________

Parent Consent for Management of Tube Feedings at School

I______________________(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's tube feedings and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County School District. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature:______________________________**Date:**____________________