Individualized Gastrostomy Tube Action and Nursing Care Plan

for _____School Year

This section to be completed by parent

Student's Name_____ DOB_____ Age_____

School _____ Grade_____ HR Teacher_____

Significant Medical History and Reason for feeding tube: _____

_____

Allergies_____

Treating Physician_____ Phone_____ Fax_____

This section to be completed by Physician

Type of gastrostomy tube: _____ Size: _____ Date of placement: _____

Change or replace feeding tube every _____ ☐ PRN

If a G/J tube, which port is used for medications? _____

Which port is used for feedings? _____

What action should be taken if the tube comes out? _____

Current Medications: _____

_____

Method of feeding: ☐ Feeding pump ☐ Gravity ☐ Other_____

School feeding times_____

Type of Formula: _____ Amount: _____

☐ Flush every _____ with _____ Amount _____

Site assessment frequency _____

SUPPLIES TO BE FURNISHED BY PARENT/GUARDIAN:

✓ FORMULA	EXTRA G-TUBE
✓ 60 CC SYRINGES	FEEDING PUMP
✓ EXTENSION TUBING FOR BUTTONS	FEEDING BAGS

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____

Florida Department of Health in Leon County

CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year_____

Student's Name: _____
DOB: _____
School: _____

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health inLeon County, School Health Division, may be giving and receiving information pertaining to the management of my child's medical condition with the following organizations:

(Please check *and* initial all that apply)

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children's Medical Services
(Name of case manager: _____)
___ [X] Florida Department of Health in Leon County (Health Department)
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician_____
(Please fill in Physician name)
___ [ ] Specialist Physician_____
(Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

_____ _____

Signature Date