Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

G-tube Feeding Plan

Student_____ Date_____ Grade_____

Date of Birth_____ School_____ Teacher_____

Address_____ Parent/Guardian_____

City_____ Zip Code_____ Home Phone_____

Emergency Contacts:

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name of formula: _____ Type of pump: _____

Gravity: ____Yes _____No

Volume to be given: _____ml(milliliters) over_____ minutes

Feeding times: _____ _____ _____ _____

Position during feeding _____

Position after feeding _____

Note to Health Care Provider/Parent/Guardian:

The parent/guardian will be notified if a tube becomes clogged or dislodged.

School personnel cannot forcefully flush or replace a feeding tube in the stomach.

Feeding formula must be sent to school in the original unopened container.

Additional Health Care Provider's comments:

_____

_____

-over-

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date_____

Physician Information

Print Name of Provider_____ Clinic Name_____
Phone Number_____ Fax Number_____
Address_____

Signature of Provider_____ Date_____

Revised 5/2019