Gastrostomy Feeding Management and Treatment Plan

Physician/Parent Authorization for Gastrostomy Feeding & Care

*This form is to be renewed annually and as changes occur: DATE OF PLAN _____
Prescribed in-school medication or procedures requiring administration via Gastrostomy tubes will be administered by a school nurse or someone properly trained by a registered nurse.

Scholar: _____ **Birth date**: _____ **Grade:** _____
Diagnosis: _____**Type of button/tube:** _____

TO BE COMPLETED BY PHYSICIAN:
Please respond to the following questions based on your records and knowledge of the scholar's health history/concerns.

Procedure for Feeding: (Parent/guardian to provide all supplies for procedures)

1.) Type of formula/fluid to be given via Gastrostomy tube/button:
- ☐ Pre-Packaged Formula (ex: Pediasure, Jevity): _____
- ☐ Homemade Formula (Parent prepares at home based on physician's orders)
  If Homemade formula, list the ingredients and corresponding amounts/volumes/proportions that should be included:
  _____
  _____
  _____
  _____

2.) Amount of formula/fluid to be given at each feeding: _____
3.) Total number of feedings to be given at school: _____
4.) Times to be administered at school (*give range of times when possible; may vary up to ½ hour to accommodate school schedule*): _____
5.) ☐ Administer by gravity drip or bolus feed over a period of _____ minutes.
☐ Administer by infusion pump at a rate of _____ cc's per hour.
6.) After each feeding, flush tubing with _____ cc's of water.
7.) Clean extension set and syringe/bag with warm water after each feeding.
Replace parenteral feeding bag _____. Replace extension set _____.
Additional recommendations: _____

2. Special Considerations:

1.) The scholar's head and shoulders should be raised 45 degrees or more during feedings. The right side lying position may be used if a sitting position is contraindicated. Other positions for this child: _____
_____
2.) Procedure for checking residuals, if prescribed: _____
_____
3.) Procedure for clearing button if clogged: _____
4.) Infusion changes for moderate to severe gagging during feeding: _____
5.) Recommendations for care of skin around g-tube stoma site: _____
6.) Other considerations/instructions: _____

******In the event that the tube becomes dislodged, the parent will be notified and EMS contacted if needed. Uplift Education's staff does not replace dislodged tubes.***

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3. Oral Feedings:

1.) ☐ This scholar MAY have foods/liquids by mouth. ☐ This scholar MAY NOT have any foods/liquids by mouth.

2.) **TEXTURE MODIFICATION:** ☐ Thin pureed ☐ Thick pureed ☐ Ground
☐ Mechanical soft ☐ Regular ☐ Other: _____

LIQUID MODIFICATION: ☐ Thin/regular ☐ Nectar ☐ Thin pudding/honey ☐ Thick pudding

3.) Amount of food/liquid to be given at each **oral** feeding: _____

4.) Times during the school day for **oral** feedings: _____

5.) Special **oral** feeding techniques/instructions: _____

_____

Physician Name (please print): _____ **Signature** _____**Date** _____

Clinic/facility _____ **Phone**_____ **Fax**_____

Clinical Dietitian: _____ **Phone** _____

TO BE COMPLETED BY THE PARENT:

I the undersigned, the parent/legal guardian of _____ request that the above Gastrostomy Feeding Management and Treatment Plan be implemented for my scholar. Delivery of this form to the school nurse constitutes my participation in developing this Plan, and is my consent to implement this Plan. I will notify the school immediately if the health status of my child changes, if I change physicians or emergency contact information, or if the procedure is canceled or changes in any way. I understand that my scholar's health information may be shared with individual employees with Uplift Education on a need to know basis.

If the physician has prescribed a homemade formula for my child, I agree to follow the recipe as indicated on page 1 of this document for feedings to be given at school.

Signature_____ Relationship _____ Date _____

Phone (Hm)_____ (Wk)_____ (Cell) _____