Individualized G-Tube Plan 2024-2025 School Year

Child's Last Name:_____ **Child's First Name:**_____

Date of Birth:_____**Diagnosis:** _____

Type of Tube: _____

Tube Placement Date: _____ **Date Updated:** _____

Order for G-Tube Feeding Procedure

To be completed by the child's physician and returned to the school nurse. If tube weaning, an updated written plan is required and can be signed by the treating physician, dietician, or feeding therapist. Parents, please highlight all changes.

Treatments Needed During School Hours

☐ Feeding by Syringe ☐ Feeding by Pump ☐ G-Tube Medications

Feeding - Specify diet to be given during school day Position: _____ Feeding Type: _____ Amount: _____ Frequency: _____ Length of Time / Rate:_____ Free water time: _____ Free water amount: _____ Minutes of wiggle room for start of feeds? _____	**Special Instructions:**
Flushing (check one) ☐ I DO NOT order G-tube to be flushed ☐ I DO order G-tube to be flushed ☐ Before feeding/medication with _____cc water ☐ After feeding/medication with _____cc water	**Residual** (check one) ☐ I DO NOT order to check for residual ☐ I DO order to check for residual Residual notes:

Medications

Drug	Dosage	Frequency

Dislodged Tube - Cover stoma with sterile gauze and notify parent/guardian

The parent/guardian has received training and may reinsert tube. ☐ Yes ☐ No

School nurse may reinsert g-tube: ☐ Yes (Parents/guardians will be contacted prior to re-insertion) ☐ No

Extra button at school? (optional): ☐ Yes ☐ No Parent/Guardian Initials _____ Nurse Initials _____

GI Physician Name: _____

Phone: _____Fax: _____

GI Physician Signature: _____Date: _____

School Nurse Initials _____