Gastrostomy Action Plan

Keller ISD Health Services Department

NAME: _____ **DOB:** _____ **Teacher/Grade:** _____

Emergency Contact #1: _____	**Preferred Contact #:** _____
Emergency Contact #2: _____	**Preferred Contact #:** _____
Physician Treating Condition: _____	**Preferred Contact #:** _____
Preferred Hospital: _____	

DIAGNOSIS/CONDITION: **GASTROSTOMY**

Type of G-Tube: _____

Insertion Date: _____

INSTRUCTIONS FOR FEEDING:

1. Formula: _____
2. Amount: _____
3. Method of Administration: _____
4. Equipment required (supplied by parent): _____
5. Flushed with _____cc water
6. Frequency of feeding: _____
7. Duration of feeding: _____
8. Student Position: _____
9. Cleaning Method: _____
10. Residual: Yes ☐ No ☐ If yes, hold feeding if residual more than _____ cc's
11. Precautions, unfavorable reactions: _____
12. Disposition of student following procedure: _____
13. Other pertinent information: _____

***If tube/button becomes dislodged, stoma will be covered with gauze and parent will be notified. Any other additional action? _____

MEDICATIONS TO BE ADMINISTERED DURING SCHOOL

(Medication Authorization form is required if administered during school):

Medication Name	Route	Dosage	Time

Following all applicable laws, rules and regulations, the prescribed procedure may be performed by the School Nurse, Licensed Vocational Nurse or trained unlicensed employee. The prescribed procedure required during the school day will be administered on receipt of this completed form, along with any special equipment items.

PHYSICIAN – Please complete above information and sign;

Physician Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

NAME: _____ DOB: _____Teacher/Grade: _____

Diagnosis/Condition: GASTROSTOMY

ADDITIONAL INFORMATION: (Include equipment location)

Precautions, unfavorable reactions	• G Button pulled out of stoma- cover with clean gauze and notify nurse and parent immediately • Skin breakdown around site exhibited by redness, drainage, irritation and bleeding- treat per physician's guidelines-notify nurse and parent • Aspiration of fluid into lungs exhibited by difficulty breathing or change in color- Stop feeding immediately. Notify nurse. Call 911 and notify parent • Intolerance of feeding exhibited by nausea, vomiting, cramping, coughing and/or gagging- Stop feeding. Check the rate of the feeding; may need to be decreased. Notify nurse and parent
Trained Staff/Location ***School Nurse must complete delegation/training documents**	
Buddy Nurse Location	

Acknowledged and Received by:

Parent Signature: _____ Date: _____
Trained Staff Signature: _____ Date: _____
RN Signature: _____ Date: _____
LVN Signature: _____ Date: _____

☐ Gastrostomy EAP electronically sent via Laserfiche to all staff directly involved with student services. Date: _____

Revised 5/21