Gastrostomy
Individual Health Care Plan (IHP)

Diagnosed condition: School Year

Student Legal Last Name First Name MI

Birthdate School Grade Other ID

Transportation: ☐ Walker ☐ Self Transported ☐ Bus Rider Bus Route Number

Parent/Guardian Information

Parent/Guardian Primary phone - -

Work phone - - Cell phone - -

Parent/Guardian Primary phone - -

Work phone - - Cell phone - -

Healthcare Provider and Hospital Information

Healthcare Provider Name Phone - -

Preferred Hospital Phone - -

Emergency Contacts

Name Phone - - Relationship

Name Phone - - Relationship

Name Phone - - Relationship

Parent/Guardian Signature ______________________ Date ____________

School Nurse Signature ______________________ Date ____________

Healthcare Provider's Signature ______________________ Date ____________

The following section is to be completed by the prescribing healthcare provider:

Tube Feeding/Treatment Authorization Form

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that the prescribed treatment may be administered by trained non-medical personnel.

Diagnosis for which tube feeding will be required in school:

Date of initial gastrostomy tube placement:

Type of gastrostomy appliance placed:

Long Tube Low-profile G-Tube G-J Tube Other, describe

Type of tube feeding formula: Amount

Type of tube feeding flush: Amount

Time and frequency of feedings:

Is it necessary to measure residual stomach contents? Yes No

If yes, please indicate the residual amount that would prohibit feeding at the prescribed time: cc total volume.

Tube feeding method: Bolus by gravity Bag Syringe If pump malfunctions may do bolus feeding

Mechanical pump - Type of pump: Rate of flow:

Is the student allowed oral feedings? Yes No If yes, type: Frequency:

Medication Orders

Medication name

Dose Time Route

Stoma Preservation Plan

In the event the G-Tube comes out or is dislodged, check all that apply:

Trained RN may preserve the stoma. (Healthcare provider to enter instructions for stoma preservation)

Notify parent/guardian immediately for reinsertion and verification of placement prior to use for feeding.

Notify parent/guardian immediately.

Notify healthcare provider immediately.

Trained RN may replace the G-Tube and the parent/guardian will complete the first feeding after reinsertion to verify patency.

Healthcare Provider's Name *(Printed)* Phone - - Fax - -

Healthcare Provider's Signature ______________________ Date ____________

School Nurse's Signature ______________________ Date ____________

A copy of this plan will be kept in the school health room and the information will be shared with others who will need to know to maintain the child's health and safety.

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