

East Allen County Schools
HEALTH SERVICES
G-Tube Feeding Care Plan

School Year: _____

Student: _____ Date of Birth: _____ Grade: _____

Type of G-Tube:

Button

Catheter

Other (specify): _____

Name of formula: _____

Gravity: Yes No

Feeding times: _____

Positions:

During feeding: _____

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 tube in the stomach.
- Feeding formula is preferred in the original unopened container.

Additional health care provider's comments: _____

Printed name of the MD, ARNP, or PA

Date

Signature MD, ARNP, or PA

Address/Phone Number

- Note to parent or guardian: signing this form shall release the East Allen County Schools and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provide.

Signature of the Parent or Guardian

Date

Relationship to Student