Chandler Unified School District #80

G-Tube Care Plan and Order for Prescribed Services

Student Name:_____DOB:_____

School:_____Grade:_____Date:_____

To Be Completed by Licensed Health Care Provider:

Name of Formula: _____

Amount to be Administered: _____

Feeding administered via: ☐ Gravity ☐ Pump

If feeding is via pump, Pump Type: _____

Flow Rate: _____

Prime tubing with: _____ mLs of: _____

Flush amount: _____

TIME of administration at school: _____

Is it necessary to measure residual volume? ☐ Yes ☐ No

If yes, will residual volume alter volume of feeding: _____

Student may self-administer this treatment. ☐ Yes ☐ No

Liquids orally at school. ☐ Yes ☐ No

If yes, How much: _____ How often: _____

Date to be discontinued: _____

Licensed Health Care Provider Acknowledgement: I am aware that the parent/guardian in conjunction with the school/district licensed registered nurse will train the staff/unlicensed assistive personnel to perform this procedure while the student attends school. *According to ADE and SNOA guidelines, if gastrostomy button comes out at school, trained nurses, health assistants/unlicensed assistive personnel may reinsert a deflated and clean gastrostomy button to keep the stoma open and then call parents. *Standards of care available upon request*

Licensed Healthcare Provider Name: _____ Phone No._____
(print)

_____
Licensed Healthcare Provider Signature *Date*

Parent Acknowledgment: I agree with the above care plan and to provide necessary equipment/supplies properly labeled for use in school. I will work in conjunction with the school/district licensed registered nurse to train the staff/ unlicensed assistive personnel to administer the above procedure. If the procedure changes, written verification from your licensed health care provider is required. I grant permission for the registered nurse to communicate directly with the above-named provider, regarding any questions or concerns regarding this procedure or health related issues. I will notify the school of changes in procedure or provider.

Parent/Guardian Name: _____ Phone No. _____

Parent/Guardian Signature: _____ Date: _____

Revised 3/10/23.