

Individualized HealthCare Plan(IHP)/Emergency Action Plan for Student with a Tube Feeding

Student Name: _____ **DOB:** _____ **Grade** _____

Parent/Guardian _____

Phone (h) _____ (w) _____ (c) _____

Physician _____ **Phone** _____

Fax _____

Specifics of Management:

Diagnosis related to need for tube feeding: _____

Is child allowed oral feedings? _____ Yes _____ No

If oral feedings are allowed, what, if any food/fluid will be given at school?

Will medications be given via tube ? _____ Yes _____ No

If so, please list any specific

directions _____

Product to be used for tube feeding _____

Amount: _____ Approximate Time _____

Give by gravity _____ or bolus _____

Water flush amount before feeding _____ after feeding _____ or NO FLUSH _____

Additional Comments: _____

Physician Consent for Student with a Tube Feeding IHP

I have reviewed and approved this management plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly.

- Nurse may replace G-button with proper training.
Training on G-button replacement will be provided
by: _____

Other Comments: _____

Physician/Health Care Provider Signature

Date

Parent Consent for Student with a Tube Feeding IHP

I, as parent/guardian, concur with the above management plan, and will provide the necessary supplies and equipment, notify the school nurse if there is any change in our child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

Parent/Guardian Signature

Date