Gonzales Independent
School District
Excellence For All

Individual Health Care Plan
Enteral Feedings per GI Tube

Student Name: _____ School Year: _____
Date of Birth:_____ Teacher/Grade:_____
Parent/Guardian: _____ Number: _____
Parent/Guardian: _____ Number: _____
Emergency Contact: _____ Number: _____
Treating Physician: _____ Number: _____
Physician Address: _____Fax: _____

Medical Diagnosis: _____
Type of Feeding Tube: _____Date Placed: _____
Will student be needing Tube Feedings during school hours? _____ Yes _____ No
Can student take anything by mouth? _____Yes _____ No

Medical Orders

(**One type of feeding per form; additional will need additional forms**)
Name of Feeding administered via tube: _____
Feeding times while at school: _____ & _____ & _____

Gravity_____ Pump_____ Bolus _____ (please check **one**)
Flow Rate (**Pump**): _____ml/hr Volume to be given: _____ ml_____ min (**Gravity**)

Volume of water before feeding: _____ml
Volume of water after feeding: _____ml

Position During Feeding: _____ After Feeding: _____for _____min

Medication to be given before or after feeding? _____Yes* _____ No
*A **Medical Order for Health Services and Procedures** form will need to be completed for medications.

Emergency Plan and Directions to follow should the tube become dislodged: _____
_____

_____

Check placement of tube before feeding: _____Yes _____No
Check residuals before feeding: _____Yes _____No
Instructions if residuals are present: _____
***All supplies needed for the administration of enteral tube feedings must be provided by the parent.**

Physician Signature: _____ Date___/___/_____

Parent Permission to Administer Tube Feedings
____ I give permission that the above tube feeding be given to my child _____ by the nurse and/or trained school personnel, as prescribed by my child's physician.
Parent/Guardian Signature: _____ Date___/___/_____