Cherokee County School District

TUBE FEEDING ACTION PLAN

Student _____ D.O.B_____

School_____ Teacher_____ Grade _____

Parent/Legal Guardian_____

Phone: Home_____ Work _____ Cell _____

Physical condition/reason for Tube Feed _____

_____

Is student to receive anything by mouth? ☐ Yes ☐ No

If Yes, list dietary choices_____

_____

Name of procedure_____

Name of formula_____

Length of time to administer formula_____

Time to administer formula at school_____

Is anything to be added to formula? ☐ Yes ☐ No

If Yes, please add _____

Amount of additive_____ Time to be added_____

Feeding may be done by: ☐ Teacher ☐ Nurse ☐ Paraprofessional ☐ Other

(Parent will provide supplies/equipment.)

If the G tube becomes dislodged at school, the G tube will not be replaced by school personnel. Stoma will be covered, and the parent/legal guardian will be called immediately. If the parent/legal guardian does not arrive after one hour of the G tube becoming dislodged, 911 will be activated. Any request beyond the above protocol may warrant a letter from the physician.

☐ Parent/legal guardian has been trained to reinsert the G tube.

I, _____, authorize the physician's office to release confidential information about my child.

_____ _____

Parent/Legal Guardian's Signature Date

_____ _____

Physician's Signature Date

_____ _____

Physician's Printed Name Physician's Phone Number