SOUTHERN WILL COUNTY COOPERATIVE for SPECIAL EDUCATION

ADMINISTRATIVE DISTRICT: TROY 30C

DR. TIFFANY FREY
Executive Director

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GRACE DOYLE
Assistant Director

Enteral Feeding Emergency Action Plan

Student Name:_____ Date:_____
School: _____ Grade:_____

What type of tube does the student have?
☐ NASOGASTRIC ☐ GASTROSTOMY ☐ JEJUNOSTOMY ☐ GASTROSTOMY-JEJUNOSTOMY

Will the student need to be fed or have feeding started at school?
☐ NO ☐ YES (Complete the following information)

Method of Delivery

☐ **GRAVITY:** If given during school hours, please complete the following:

Time:_____Formula Type:_____Dosage (amount):_____Flush Type/Amount:_____

☐ **BOLUS/PUSH:** If given during school hours, please complete the following:

Time:_____Formula Type:_____Dosage (amount):_____Flush Type/Amount:_____

☐ **PUMP:** If given during school hours, please complete the following:

Start time:_____Rate:_____Formula Type:_____Flush Type/Amount:_____

Care Instructions

Will your student need routine care while at school?
☐ NO ☐ YES (Complete the following information)

☐ Clean with antiseptic solution, dry the area and apply split gauze as needed
☐ Apply _____ cream at this time: _____

Please note that split gauze, special cleaning solution and/or cream will need to be supplied by parent/guardian.

In case of an emergency

If the G-tube happens to come out during school hours, how long can the tube be out before the stoma closes?_____
Please list the procedures staff should follow if the tube comes out during school hours:_____

_____

_____

Call 9-1-1 immediately if:_____

Parent/Guardian Signature:_____ Date:_____
Healthcare Provider Signature:_____ Date:_____
Healthcare Provider Name (Print):_____ Phone:_____