Must be completed by a
Licensed Health Professional

Spencer County Public Schools Health Services

INDIVIDUAL HEALTH CARE PLAN
G-Tube

PRINT Student Name: ______________________________ School Year________________
Date of Birth: ______________________________ Teacher/Grade______________
Date of Diagnosis: ______________________________ Bus Route # ________________

Emergency Contacts:
Name: ______________________________________ Numbers: ______________________________
Name: ______________________________________ Numbers: ______________________________
Name: ______________________________________ Numbers: ______________________________
PRINT Treating Physician Name:__________________________ Number: _________________
Physician Address: _______________________________________ FAX # _________________

MEDICAL DIAGNOSIS ____

Student will need G-tube Feeding while at school ___No ___Yes
Can student take anything by mouth? ___No ___Yes

Type of G-Tube______________________ Date of Placement: ______________________

Name of formula: ____________________
Gravity: ___No ___Yes
Pump to be used: ___No ___Yes Type of Pump: ____________________Flow Rate:_____cc/hr

Steps to confirm tube placement:____

Volume to be given: ________cc over ________minutes
Volume of water before feeding: _______cc
Volume of water after feeding: _______cc
Feeding times while at school: ___________ ___________ ___________

Positions: During Feeding: ______________________ After Feeding: ___________________________

Medication to be given with feeding: ___No ___*Yes- Name of Medication/Instructions:__________
____
____

***A "Permission for Prescribed or Over-the-Counter Medication" form must be completed by parent and physician to administer any medication at school.**

List of supplies that parents will provide to school: ____
____

Any problems/concerns/reasons to withhold feeding:____
____

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

PHYSICIAN/MEDICAL Signature ______________________________ Date ________________

PARENT Signature ____ Date ________________

STAFF/SCHOOL NURSE Signature ____________________________ Date ________________