717 JORDAN PUBLIC SCHOOLS
500 Sunset Drive
Jordan, Minnesota 55352
952-492-6200 main | 952-492-4445 fax

DISTRICT NURSE
jordannurse@isd717.org

FEEDING TUBE EMERGENCY CARE PLAN AND ORDERS

Dear Parent(s) Guardians of: _____

According to our recent records you have indicated that your child has a history of tube feedings. To best care for your child while in school, please have his/her physician fill out the **Feeding Tube Care Plan** before the start of the school year. Please provide an emergency kit in the event the feeding tube becomes dislodged.

The forms on the following pages must be completed and signed before the start of school.

Please return the enclosed forms as soon as possible either by mailing, faxing or in person at the following school so that we may best care for your child should the need arise:

_____ **Jordan Elementary School** Address: 815 Sunset Drive, Jordan, MN 55352
Fax: 952-492-4446

_____ **Jordan Middle School** Address: 500 Sunset Drive, Jordan, MN 55352
Fax: 952-492-4450

_____ **Jordan High School** Address: 600 Sunset Drive, Jordan, MN 55352
Fax: 952-492-4425

Please call or email us if you have any questions or concerns.

Thank you,

District Nurse - JMS
952-492-4232
jordannurse@isd717.org
Fax: 952-492-4450

Kristina Stresnak LPN
Jordan Elementary School
952-492-4278
Fax: 952-492-4446

Jenn Passe RMA
Jordan High School
952-492-4410
Fax: 952-492-4425

Tube Feeding Orders

Name of Student:_____ DOB:_____
School Year: _____ Teacher:_____ Grade:_____

Emergency Contacts:

_____

Parent/Guardian Phone Number(s)

_____

Parent/Guardian Phone Number(s)

Physician Name:_____ Phone:_____Fax:_____

Tube Type: ❑ NG Tube ❑ G-Tube ❑ J-Tube ❑ GJ Tube ❑_____

Date Tube Placed:_____ Brand:_____
Stoma is mature: ❑ Yes ❑ No

Nutritional Supplement/Formula Type:_____

Frequency during the school day for tube feeding_____

Length of time for tube feeding:_____

Amount to be administered_____

Feeding Method: ❑ bolus ❑ gravity ❑ pump rate:_____

Additional fluid requirements to flush or for hydration:_____

Confirm Feeding Tube Placement: ❑ No ❑Yes (steps to confirm)

_____

_____

Check for Residual: ❑ No ❑Yes (Specify
_____)

Student is able to take food orally: ❑ No ❑Yes (please specify)

_____

_____

Frequency or extension tubing, medication and flush syringe change:_____

Additional information:

_____

Name of Student:_____ DOB:_____

Medications to be administered at school:

Medication Name	Dose	Amount	Frequency	Route

EMERGENCY ACTION PLAN FOR DISLODGED TUBE

***Replacement tube to be kept at school in the event of an emergency.**

❑ The school nurse should attempt to replace the g-tube. Should the tube not be able to be reinserted, cover with clean gauze and notify the parent immediately.
*****Instructions for replacement are to be provided by the physician along with this order*****

❑ The school nurse should **not** attempt to replace the g-tube. The stoma should be covered with clean gauze and the parent notified immediately.

Physician Signature_____**Date**_____

I want this plan implemented for my child while in school. I give permission for exchange of confidential medical information between school staff and my child's health care providers on a need to know basis. I release school personnel from liability in the event adverse reactions result from implementation of the above emergency plan and subsequent administration of emergency medication(s). I give permission for school staff to call 911 if necessary.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____