EMERGENCY CARE PLAN-GASTROSTOMY

Year: Current School Year

Student Name Date of Birth:

No Image Available

Parent/Guardian:	Guardian(s) Primary	Hm Phone:	Guardian(s) Primary Phone
Address:	Guardian(s) Primary Address Box	Cell Phone	Guardian Primary Cell Phone Gaurdian 2 Primary Cell Phone
Emergency Contact	Emer Contact 1 Name	Phone:	Emer Contact 1 Primary Phone
	Emer Contact 2 Name	Phone:	Emer Contact 2 Primary Phone
Physician:	Physician	Phone:	Physician Phone
Preferred Hospital:	Hospital	Allergies:	

Current Medications:

HEALTH CONCERN: (Enter diagnosis here)	
History	
Special Precautions	
Type of Gastrostomy tube	
Type of formula, amount, time of day	
Hydration	
Medication delivered through G-Tube	

EMERGENCY INTERVENTION

Moderate Symptoms	**Immediate Response**	TIME Initials
Coughing Difficulty or resistance infusing liquid through tube	Stop Feeding immediately Clamp Tube Allow student to rest	
Severe Symptoms	**Immediate Response**	TIME Initials
Difficulty Breathing Skin color changes, with or without vomiting	***Call 911*** *Notify parent,* *Notify school nurse* *Notify principal* *Do not leave the student unattended*	

Parent: Date:

School Nurse RN: IHP Written By Date: Todays Date

A copy of this plan will be kept in the school office and copies will be given to:

☐ Para Pro ☐ Trans ☐ Teacher ☐ PE ☐ Student Services ☐ Health Room ☐ Other: ☐ Sec- Principal

CONFIDENTIAL INFORMATION **SHRED PRIOR TO DISCARD**