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