GASTROSTOMY TUBE/BUTTON FEEDING EMERGENCY ACTION PLAN/504

Place student picture here

NAME:			Birthdate:		Teacher:	
Grade:		School:		☐ Bus #		☐ Walk ☐ Drive
Doctor:		Phone:		Fax:		Preferred Hospital:
Gastrostomy Tube/Button Feeding Condition/Concern:						

Wears medical alert bracelet? YES □ NO □

Action:

- **If the tube or button falls out, THIS IS NOT AN EMERGENCY. Save tube or button for reinsertion. Cover the site with gauze, and call the parent immediately. DO NOT REPLACE the tube/button.**

Potential symptoms/concerns:

Treatment times:

Equipment/environment needed:

Specific instructions from LHP:

LHP Signature	Date	Telephone: Fax Number:
LHP Printed Name	Start Date:	End Date:

(Spokane Public Schools Health Services revised 5/20)

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name
Home Phone
Work Phone
Other

Name
Home Phone
Work Phone
Other

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

- A new health care plan for health conditions must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and request/authorize trained school employees to provide this care in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this plan can only be discontinued by the LHP.
- I authorize the exchange of information about my child's health condition between the LHP office and the school nurse.
- Rescinding the release for the exchange of information between the school nurse and the LHP will cancel this health care plan/order.
- *My signature below shows I have reviewed and agree with this health care plan.*

Parent/Guardian Signature Date

For District Nurse's Use Only		
School Nurse Signature	**Date**	**Phone:**

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.

*****Keep plan readily available for substitutes.*****