

School: _____ School Year: _____

Feeding Tube Care Plan for School Administration

Student Name: _____ DOB _____

Type of Feeding Tube: _____ Size: _____ FR _____ cm

Formula: _____

Feeding Method:

- Bolus
- Gravity Drip
- Continuous Feeding Pump (type of pump _____)

NPO: Yes No Comments: _____

Feeding Times at School:

Time	Formula Amount	Water Flush Amount	Rate per hour

Feeding Position: _____

Special Instructions: _____

*If feeding tube needs to be replaced at school due to an emergency, the nurse will maintain feeding tube site with a clean catheter and notify parents. Feeding tube will not be replaced at school by the nurse, and must be done by a parent before use at school will continue.

Physician's Signature: _____ Date: _____

Printed Name: _____ Office Number: _____

I understand that I am responsible to provide all supplies needed to follow the physician's order above. I will bring supplies to the school nurse as needed.

I give my permission for a trained school staff member to administer the above prescribed feeding during the school day.

Parent/Guardian Signature: _____ Date: _____