

School: _____ School Year: _____

Individual Feeding Care Plan for School Administration

Student Name: _____ DOB: _____

Feeding Method:

- Bolus Tube Feeding
- Gravity Drip Tube Feeding
- Continuous Feeding Pump (type of pump _____)
- Oral Feeding Precautions (see "Dysphagia Diet" orders below)

NPO: Yes No Comments: _____

Feeding Tube Type: _____ Size: _____ FR _____ cm

Formula: _____

Tube Feeding Times at School:

| Time | Formula Amount | Water Flush Amount | Rate per hour |
|------|----------------|--------------------|---------------|
| | | | |
| | | | |
| | | | |
| | | | |

Tube 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.

Dysphagia Diet Instructions:

Food Consistency: _____

Liquids Consistency: _____

Special Instructions: _____

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: _____