DUNLAP COMMUNITY UNIT SCHOOL DISTRICT #323

Feeding Care Plan

Must be completed by a Licensed Health Professional

School Year _____________ - _____________

Student's Name: ____Birth Date:____________________

Parent(s): ____ School:_____________________________

Home/Work Phone: ____________________________Cell Phone:____________________________Bus:Yes___ No___

PRINT Treating Physician Name:____Number:_______________________

Medical Diagnosis: ____

Student will need tube feeding while at school?_____No_____Yes

Type of G-Tube____

Name/Type of Formula:____

Gravity:___No___Yes

Pump to be used:___No___Yes   Type of Pump:______________________________Volume:____________ml/cc

Flow Rate:_____ml/cc per hour

Feeding times while at school:____________ ____________ ____________

Check tube placement prior to feeding:____No____Yes   Specific instructions____________________________________

____

Flush with ____________cc water

Positions :During feeding:____________________________After feeding:_________________________________

Medication to be given with feeding:_____No _____Yes- Name of Medication/Instructions:________________

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***A medication authorization form must be completed by parents and physician prior to any administration of medications while at school.**

Emergency Plan and Directions to follow should the tube become dislodged:_____________________________

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Physician signature____Date_________________________

Parent signature____Date_________________________

Nurse Signature____Date_________________________

Other Notes: ____

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