Dunlap Community Unit School District #323

Dates Updated:

CONFIDENTIAL

FEEDING CARE PLAN

Student Name: ______________________ Date of Birth: __________ School Year: ________

Teacher: ____________________ Attending School: ____________________

Grade: ____________ DOR: Dunlap Unit SD 323

Contact Information (see attached **Emergency Information Sheet**):

Physician Treating Medical Condition: ____________________ Ph#: __________ FAX#: __________

Hospital Choice (please check one): ☐ OSF St. Francis ☐ UnityPoint Health - Methodist ☐ Proctor Hospital ☐ Pekin Hospital

Medical Diagnosis Affecting Feeding:

Allergy Care Plan?: ☐ Yes ☐ No

Diet: Tube Feeding: ☐ G tube ☐ J tube Type: ____________________ ☐ Tube Fed/Nothing by mouth

Formula: ____________________ Amount fed orally: ____________________ ☐ Tube & Oral Fed

Oral Feeding: ☐ Self ☐ Assisted ____________________

Food Consistency: ☐ pureed ☐ ground ☐ chopped ☐ mashed ☐ bite-sized

Liquid Consistency: ☐ no liquids ☐ thin liquids Thickened liquids: ☐ nectar ☐ honey ☐ pudding

Feeding Schedule (times and amounts for feedings, include times/amounts for tube flushes as well):

Feeding Recommendations:

1. Positioning: ____________________

   Seating: ☐ regular sitting ☐ wheel chair ☐ special seating (describe): ____________________

   Keep student in upright position __________ minutes after meal. Offer a drink after __________ bites.

2. Food Presentation: ☐ bottle ☐ cup ☐ straw ☐ spoon ☐ fork ☐ knife ☐ bowl ☐ plate
3. Equipment Used (for food preparation/feeding/oral hygiene):

Oral Hygiene: ☐ Independently clears food from mouth ☐ Requires assistance to clear food from mouth

☐ Oral prosthesis Cleaning schedule:

Medications Infused Through the Feeding Tube (medications given at school require a **Medication Permit**):

Drug Name: ____________________ Dose: __________ Time Given: __________

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Drug Name: ____________________ Dose: __________ Time Given: __________

Additional Precautions/Comments/Recommendations/Compensatory Strategies:

Field Trips: Teacher will take **Feeding Care Plan** and any equipment/medication needed on field trips along with the student's **Emergency Information Sheet.** Teacher will be instructed on the correct use and procedure for equipment and medications.

1. As parent/guardian of I give permission for this plan to be available for use in my child's school, and for the school nurse to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physician that this plan may be carried out by school personnel other than the school nurse. The school's registered nurse is responsible for the delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and **it is the responsibility of the parent to notify school nurse of these changes.**

Physician Signature ____________________ Date: __________

Parent/Guardian Signature ____________________ Date: __________

School Nurse Signature ____________________ Date: __________

Homeroom Teacher Signature ____________________ Date: __________

School Staff Signatures ____________________ ____________________

School Staff Signatures ____________________ ____________________