INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name:

Health Concern: **TUBE FEEDING**

Date of Birth: Student ID:

Case Manager: Ext:

Medical history related to feeding issues _____

_____

Swallow study completed? ☐ No ☐ Yes (If yes, copy needs to be on file with current recommendations.)

Fundoplication with wrap ☐ No ☐ Partial ☐ Complete

Type of external port _____ Size _____

Any irregularities _____

Leakage _____

Need for labeled supplies at school _____

Venting needed? ☐ No ☐ Yes

Procedure _____

_____

Typical symptoms of distress _____

_____

If tube becomes disengaged ☐ Call Parent ☐ Call 9-911 ☐ Other - _____

_____

CURRENT STATUS OF TUBE FEEDINGS

Flush w/ water after feeding? _____

☐ Pediasure Amount / Rate / Frequency _____

☐ Other Amount / Rate / Frequency _____

☐ Water

- ☐ Bottled Amount / Rate / Frequency _____
- ☐ Tap Amount / Rate / Frequency _____

☐ Gravity Position Needed _____

☐ Syringe Position Needed _____

Goal for tube feedings _____

_____

CURRENT STATUS OF ORAL FEEDINGS

Amount / times per day _____

Texture _____ Liquids _____

Preferences _____

Goal for oral feedings _____

_____

Food Allergies _____ Typical symptoms _____

The following individuals have reviewed this Health Care Plan and support its implementation.

Parent / Guardian Signature Date | Administrator Signature Date | Doctor Signature (required) Date