ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

School Year 2024-2025

FEEDING Care

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

Child's picture Face only

This packet MUST be completed, signed, and ATTACHED to a Feeding Medical Action Plan (MAP). Please download, complete the packet and return to the main office.

Student's Name: _____ School: _____

Date of birth: _____ Age: _____

Grade: _____ Teacher**:** _____

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2024-2025 school year.

Your child's health care provider will choose to either use their own MAP template, OR the Feeding MAP template within this packet.

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

REQUEST FOR LICENSED HEALTHCARE PROVIDER FEEDING ORDERS

Student Name: _____ DOB: _____ School Year: 2024-2025

Dear Parent(s)/Guardian(s) and Licensed Healthcare Provider:

To ensure safe school feeding, adequate nutrition and hydration, we request that you complete, sign and return the information below. **Physician authorization and parent consent is valid for one school year only.**

Please check and fill in ALL that apply:

☐ Student is dependent
☐ Student may perform self-feeding
☐ Foods to avoid due to allergies/sensitivities: _____

☐ May need assistance with the following/other instructions or restrictions: _____

_____

☐ Liquid
- ☐ No restrictions ☐ Thin liquids ☐ No thin liquids
- ☐ Consistency liquids
  - ☐ Nectar ☐ Honey ☐ Ultra thick (pudding consistency)
- ☐ Thickener
  - ☐ Amount of thickener per amount of liquid: _____
  - ☐ Nutritional supplements

  ☐ Type: _____ ☐ Amount: _____

☐ Solid food
- ☐ No restrictions
- ☐ Pureed ☐ Chopped ☐ Soft ☐ Mashed ☐ Bite size ☐ Moist

☐ Positioning:
- ☐ Upright sitting posture
- ☐ Chair/Seating Device (Ex. Personal wheelchair, tomato chair)
- ☐ Head position/support (Ex. Midline)
- ☐ Trunk control (Ex. Harness)
- ☐ Food placement (Ex. Direct to mouth)
- ☐ Student uses communication or signals during feeding (Ex. Visual and tactile aids)
- ☐ Avoid traditional choking hazard shapes, textures and sizes

☐ Procedures:
- ☐ Amount of food per bite (Ex. ½ teaspoon, size of a goldfish): _____
- ☐ Wait time (Allow time for student to swallow multiple times between bites, ex. One bite at a time):

  _____

  ☐ Behavior techniques (Ex. Redirection for fatigue/irritability) _____

  _____

☐ Tube Feeding:

☐ Gastrostomy (G) ☐ Gastrojejunal (GJ) ☐ Jejunal (J)
☐ Nasogastric (NG) ☐ Nasoduodenal (ND) ☐ Nasojejunal (NJ)

☐ Product/Formula name: _____

☐ Pump Feed; Type of Pump and which port: _____

☐ Amount; Stop time (mL/hr): _____ OR ☐ Amount; Continuous feed (mL/hr)

☐ Additional instructions: _____

☐ Bolus feed; ☐ Push ☐ Gravity

☐ Amount/over how many minutes: _____

☐ Additional instructions: _____

☐ Flush instructions (pump or bolus): _____

☐ Water Hydration:

☐ Amount/how often: _____

☐ Additional instructions: _____

☐ G-Tube Support/Dislodgement/Fall out:

☐ Action required by registered nurse, if available, to replace g-tube
☐ Action required by school staff, if registered nurse is not available: **See RCS protocol**
☐ Student may perform self-care with tube feeding and/or tube placement

Provider's Name: _____ Hospital and/or Clinic Name: _____

Street Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

HEALTH CARE PROVIDER SIGNATURE: _____ Date: _____

Parent Name: _____ Signature: _____Date: _____

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Feeding Tube Dislodgement/Replacement

If a tube falls out:

1. Call parent/guardian/adult designee (emergency contact) **IMMEDIATELY**

2. While awaiting parent/guardian/adult designee to come to school:
   - School staff will:
     - Wash hands, put on non-latex gloves
     - Cover hole with clean gauze, tape in place
     - Place tube in bag/container and return to adult

3. When parent/guardian/adult designee arrives to school:
   - Inserts new tube
     OR
   - Transports to health care provider for re-insertion

If a tube is partially in place, but dislodged or malfunctioning:

1. Call parent/guardian/adult designee (emergency contact) **IMMEDIATELY**

2. If needed, school staff will:
     - Wash hands, put on non-latex gloves
     - Secure device with tape

3. Parent/guardian/adult designee will decide urgency