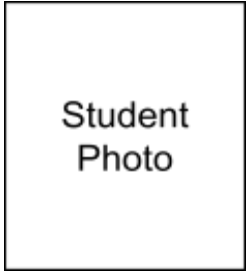




Fairbanks North Star Borough School District
Enteral Feeding Care Plan



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

MEDICAL PROVIDER AUTHORIZATION

POSITION STUDENT

Sitting upright or semi-reclining with head at a _____ degree angle.
 Remain elevated for _____ minutes after feeding is administered.
 Other: _____

ENTERAL FEEDING

<input type="checkbox"/> Check residual, then return to stomach prior to feeding. Hold feeding if residual is higher than _____ mL.
<input type="checkbox"/> Vent feeding tube prior to feeding.
<input type="checkbox"/> Administer pre-feed _____ mL of water flush.
<input type="checkbox"/> Administer feeding via <input type="checkbox"/> Gravity bolus <input type="checkbox"/> Push bolus <input type="checkbox"/> Pump (Type): _____
Formula: _____ Volume: _____ Rate (for pump): _____
Time(s): _____
<input type="checkbox"/> Administer post-feed _____ mL of water flush.

ORAL INTAKE

No Restriction NPO Clear liquid Full liquid Pureed food Other: _____

FEEDING TUBE TYPE

FEEDING TUBE SIZE

Gastrostomy (G) Gastrojejunostomy (GJ) Jejunostomy (J) Size: _____

TUBE DISLODGE MENT INSTRUCTIONS

I am attaching instructions for student's tube replacement. If an RN is available, the RN should attempt to replace the tube should it become dislodged at school. Should tube not be able to be reinserted, cover with clean gauze and notify parent/guardian immediately.

The school nurse should not attempt to replace the tube should it become dislodged. The stoma should be covered with clean gauze and the parent notified immediately.

ADDITIONAL ORDERS

MEDICAL PROVIDER NAME/TITLE	PHONE
MEDICAL PROVIDER SIGNATURE	DATE

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL



Fairbanks North Star Borough School District
Enteral Feeding Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
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PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that enteral feeding, as ordered by my child’s licensed healthcare practitioner, be provided during school hours. I will supply all necessary medications and equipment and will notify the school in writing of any changes to the care plan.

I understand and authorize trained school personnel, under the delegation and supervision of a registered nurse, to provide this care in accordance with 12 AAC 44.950–44.975 of the Alaska Administrative Code. I understand that refusal to sign this form means school personnel will not administer enteral feedings. I may revoke this authorization at any time by submitting written notice to the Health Office.

Employees and agents of the Fairbanks North Star Borough School District (“FNSBSD”) strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify FNSBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the healthcare practitioner listed on this plan and FNSBSD as part of the provision of my child’s care. I agree for the Health Office to share health information with FNSBSD staff on a need-to-know basis for my child’s safety and to foster academic success.

I understand that ANY remaining enteral feeding care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the FNSBSD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER
PARENT/GUARDIAN SIGNATURE		DATE

NURSE PLAN REVIEW

I have reviewed the Enteral Feeding Care Plan for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the healthcare practitioner, parent/guardian, Health Office, and student for the management of the student’s health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	DATE

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