



Anchorage School District

Safe Feeding Plan



Student:	DOB:	Grade:	Student ID:
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History of Condition

Diagnosis or swallow study findings (MBSS/VFSS): _____

Safe Feeding Plan includes

☐ Oral feeding only ☐ Enteral feeding only (*see reverse page*) ☐ Oral/Enteral Combo

Oral Intake Orders

Oral Intake

☐ No restriction ☐ Modified (*see below*) ☐ NPO (*see reverse for enteral feeding*)

(Levels below refer to the IDDSI – please see iddsi.org/resources/patient-handouts for more information)

Liquids

☐ Thin (lvl 0)
☐ Slightly thick (lvl 1)
☐ Mildly thick (lvl 2)
☐ Moderately thick (lvl 3)
☐ Extremely thick (lvl 4)

Solids

☐ Liquidized (lvl 3)
☐ Pureed (lvl 4)
☐ Minced/Moist (lvl 5)
☐ Soft/Bite-sized (lvl 6)
☐ Regular (lvl 7)

Student Requires 1:1 Feeding Assistance

☐ NO ☐ YES, with feeding assistant placed...
☐ across from student ☐ next to student ☐ slightly to side of student

Body Positioning

☐ Upright (90°) ☐ Semi-upright (30° - 89°) ☐ Other: _____

Head Positioning

☐ Neutral ☐ Chin tuck ☐ Head rotation ☐ Head tilt ☐ Other: _____

Adaptive Equipment

☐ Utensils: _____ ☐ Cup: _____ ☐ Bowl/plate: _____
☐ Positioning equipment: _____
☐ Other: _____

Additional Considerations: (*level of support at meals 1:2, 1:3, behaviors to monitor, accommodation/medication recommendations, etc*)

Ordering Provider:	NPI:	Phone:
Signature:	Email:	Date:



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DME for Enteral Feedings

Tube Type

☐ Gastrostomy ☐ Gastrojejunostomy ☐ Jejunostomy ☐ Other: _____

Size (Fr): _____ Length (cm): _____ Balloon Volume (cc): _____

Replacement size, length, and balloon volume (if different): _____

Additional DME (parent/guardian to provide to district)

☐ Syringes ☐ Extension set ☐ Formula ☐ Gauze ☐ Skin tape ☐ Skin prep

Please send equipment home ☐ Per parent/guardian ☐ Other frequency _____

Enteral Feeding Orders

Formula: _____ **Volume:** _____

Method (select all that apply)

Intermittent

☐ Pump bolus at _____ ml/hr

☐ Gravity bolus by syringe

☐ Push bolus by syringe

Continuous

☐ Through pump at _____ ml/hr

☐ Slow drip at _____ gtt/min

☐ Flush with water Q _____ Hours

Residual

☐ Do not check residual

☐ Check residual

☐ Return if < _____ ml ☐ Discard if > _____ ml

☐ Hold feed and call prescriber if residual is > _____ ml

Flush, Vent, Positioning

☐ Give pre-feed flush of _____ ml ☐ Give post-feed flush of _____ ml

Vent

☐ Prior to feeding ☐ After feeding ☐ PRN for s/sx discomfort

Positioning

☐ Upright (90°) ☐ High-fowlers (60° - 90°) ☐ Semi-fowlers (30° - 45°)

☐ Remain elevated for _____ minutes after feeding administered.

Additional Orders

Tube may be used for ☐ Feedings ☐ Medications ☐ Both

Site Care

☐ Dressing type: _____ ☐ Topical ointment: _____

☐ PRN ☐ Scheduled: _____

If tube is dislodged or plugged ☐ Replace tube ☐ Call provider at # _____

Additional Orders (positioning, alternative formulas prepared by parent/guardian, etc.)

Ordering Provider:	NPI:	Phone:
Signature:	Email:	Date:



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Parent/Guardian Authorization

I request that the Safe Feeding Plan outlined on this document be provided to my child. I will provide needed supplies for care in school.

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the way it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining Safe Feeding Plan 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 ASD school year calendar.

This authorization expires at the end of the current school year.

Name:	Relationship to Student:	
Signature:	Phone:	Date:

Reviewed by Nurse

I have reviewed the Safe Feeding Plan and have inquired with the Special Education Case Manager or other designated team member(s) for accuracy and to ensure that all required fields and signatures are completed before providing care to the student. I approve of the agreement arranged between the physician, parent, and student for the management of the student's health needs. I will work with the Special Education Case Manager and other designated team member(s) to conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

Nurse:	Initials:
Signature:	Date: