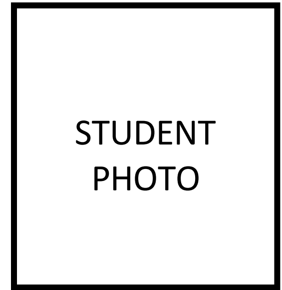
Spokane Public Schools

ENTERAL FEEDING CARE PLAN/504



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE
PROVIDER	Preferred Hospital:		☐ Walk/Drive ☐ Bus#

Oral Intake Status

☐ Nothing by mouth ☐ No restriction ☐ Other: ____________________

Feeding Tube Use

☐ Feeding ☐ Medication ☐ Both

Feeding Tube Type

☐ Gastrostomy tube ☐ Gastrojejunostomy tube ☐ Jejunostomy tube ☐ Nasoduodenal tube

☐ Nasogastric tube ☐ Nasojejunal tube ☐ Other: ____________________

MEDICAL PROVIDER AUTHORIZATION (Parent/Guardian Section page2/2)

☐ **Check then return residual stomach volume prior to feeding.**
Hold feeding if residual volume is higher than ____________**mL**

☐ **Vent feeding tube prior to feeding.**

☐ **Administer pre-feed water flush via feeding tube.**
Volume: ______________mL

☐ **Administer post-feed water flush via feeding tube.**
Volume: ______________mL

☐ **Administer bolus feeding via feeding tube.** ☐ Gravity bolus ☐ Push bolus
Time(s) to begin feeding(s): ____________________
Formula: ____________________ Volume of formula each feeding: ____________________mL

☐ **Administer pump feeding via feeding tube.**
Time(s) to begin feeding(s): ____________________
Formula: ____________________ Volume of formula each feeding: ____________________mL
Pump type: ____________________ Feeding rate: ______________mL / hour

☐ **Provide feeding tube site care.**
Time(s) dressing should be changed: ____________________
Dressing type: ____________________ Topical ointment application: ____________________
Other: ____________________

If the tube or button falls out, THIS IS NOT AN EMERGENCY. Save tube or button for reinsertion. Cover the site with Gauze and call the parent immediately. DO NOT REPLACE tube/button.

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LHP Signature		Phone: Fax:	
LHP Printed name	Date:	Start date:	End date:

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name	
Home Phone	
Work Phone	
Other	

Name	
Home Phone	
Work Phone	
Other	

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

- A new health care plan for health conditions must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and request/authorize trained school employees to provide this care in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this plan can only be discontinued by the LHP.
- I authorize the exchange of information about my child's health condition between the LHP office and the school nurse.
- Rescinding the release for the exchange of information between the school nurse and the LHP will cancel this health care plan/order.
- *My signature below shows I have reviewed and agree with this health care plan.*

Parent/Guardian Signature Date

For District Nurse's Use Only		
School Nurse Signature	**Date**	**Phone:**

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.

*****Keep plan readily available for substitutes.*****