Anchorage School District

ENTERAL FEEDING CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

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
(Provider have parent/guardian sign Authorization & Agreement page 2-2)

☐ **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: _____

☐ **Replace feeding tube if it becomes dislodged or plugged.**
Feeding tube type: _____ Feeding tube size: _____

☐ **Other nursing orders**:

LICENSED MEDICAL PROVIDER IN ALASKA (PRINTED)	TELEPHONE NUMBER
LICENSED MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

I request that the enteral feeding care outlined on this plan be given to my child. **I will provide needed medications or 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 manner in which 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 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 ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE 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 physician, parent, nurse, 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 (PRINTED)	
NURSE SIGNATURE	DATE