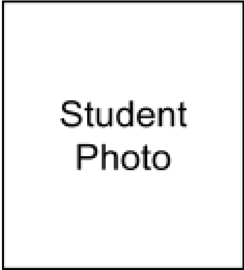
Anchorage School District

Enteral Feeding Care Plan



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

MEDICAL PROVIDER AUTHORIZATION

EQUIPMENT *(provided by parent/guardian to school nurse)*

☐ Syringes ☐ Pump ☐ Extension set ☐ Spare tube Size: __________ ☐ Formula
☐ Dressing supplies ☐ Send equipment home DAILY WEEKLY END-OF-YEAR

ENTERAL FEEDING

☐ Check residual, then return to stomach prior to feeding. Hold feeding if residual is higher than ________ mL.
☐ Vent feeding tube prior to feeding.
☐ Administer pre-feed ________ mL of water flush.
☐ Administer feeding via ☐ Gravity bolus ☐ Push bolus ☐ Pump (Type): ________________
Formula: ________________________ Volume: _______________ Rate (for pump): ______________
Time(s): ____
☐ Administer post-feed ________ mL of water flush.

ORAL INTAKE

☐ No Restriction ☐ NPO ☐ Clear liquid ☐ Full liquid ☐ Thick liquid: SPOON NECTAR HONEY

FEEDING TUBE TYPE

☐ Gastrostomy ☐ Gastrojejunostomy ☐ Jejunostomy
☐ Nasoduodenal ☐ Nasogastric ☐ Nasojejunal

FEEDING TUBE SIZE

Size: ________________

MAY USE TUBE FOR

☐ Feedings only ☐ Medications only ☐ Feedings and Medications

SITE CARE

☐ Dressing type: ___________________________ ☐ Topical ointment: _________________________
☐ PRN ☐ Scheduled: ____
☐ Replace tube if dislodged or plugged ☐ Call provider if dislodged or plugged

ADDITIONAL ORDERS

MEDICAL PROVIDER NAME/TITLE	*PHONE NUMBER*	*EMAIL*
MEDICAL PROVIDER SIGNATURE		*DATE*

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

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LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH

PARENT/GUARDIAN AGREEMENT AND 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.

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 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	
NURSE SIGNATURE	***DATE***