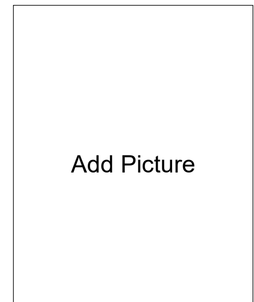
INDIVIDUALIZED HEALTH CARE PLAN

Confidential

Livonia Public Schools



Name: School Year:

Health Concern: **TUBE FEEDING**

Date of Birth: Student ID:

Case Manager: Ext:

Medical history related to feeding issues ______________________

____

Swallow study completed? ❒ No ❒ Yes (If yes, copy needs to be on file with current recommendations.)

Fundoplication with wrap ❒ No ❒ Partial ❒ Complete

Type of external port ______________________ Size ______________________

Any irregularities ______________________

Leakage ______________________

Need for labeled supplies at school ______________________

Venting needed? ❒ No ❒ Yes

Procedure ______________________

____

Typical symptoms of distress ______________________

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If tube becomes disengaged ❒ Call Parent ❒ Call 911 ❒ Other - ______________________

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CURRENT STATUS OF TUBE FEEDINGS

Flush w/ water after feeding? ______________________

❒ Pediasure Amount / Rate / Frequency ______________________

❒ Other Amount / Rate / Frequency ______________________

❒ Water | ❒ Bottled Amount / Rate / Frequency ______________________

❒ Tap Amount / Rate / Frequency ______________________

❒ Gravity Position Needed ______________________

❒ Syringe Position Needed ______________________

Goal for tube feedings ______________________

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CURRENT STATUS OF ORAL FEEDINGS

Amount / times per day ______________________

Texture ______________________ Liquids ______________________

Preferences ______________________

Goal for oral feedings ______________________

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Food Allergies ______________________ Typical symptoms ______________________

The following individuals have reviewed this Health Care Plan and support its implementation.

Parent / Guardian Signature	Date	Administrator Signature	Date	Doctor Signature (required)	Date

Revised 2017