Revised Sept 2025
Form # MM.01-05

School Year:_____

Dream • Learn • Grow
Bloorview SCHOOL AUTHORITY

FEEDING PLAN OF CARE:

STUDENT INFORMATION

Student Name:	**Date of Birth:**
Ontario Ed #:	**Age:**
Grade:	**Teacher:**

EMERGENCY CONTACTS (List in Priority and best way to reach them)

Name	Relationship	Daytime Phone/ Email	Alternate Phone
1.			
2.			

TEAM SUPPORTING FEEDING NEEDS:

Clinic responsible for feeding recommendations (HBKRH, SickKids etc.)
Names and contact information of team members:
Recommendations:
Date of last contact: Date of next visit:

ORAL FEEDING ROUTINE:

⬜ Student is dependent for feeding
⬜ Student is dependent for drinking
⬜ Student feeds independently but requires close supervision for feeding and or drinking

FEEDING MODIFICATION:

NPO	⬜ YES ⬜ NO
Safe for tastes	⬜ YES ⬜ NO **If yes: what texture:** **amount:**
Safe for oral feeds	⬜ Smooth puree ⬜ Textured Puree ⬜ Soft food ⬜ Table food
Safe for liquids	⬜ Thin liquids ⬜ Thickened liquids **If thickened to what consistency:** ⬜ Mildly thick ⬜ Moderately thick

Drinking	**Drinks from: ⬜ EZPZ cup ⬜ Cut out cup ⬜ Straw cup ⬜ Sippy cup** **Other cup/bottle:**
Modifications	**⬜ Single sips ⬜ Slow pace ⬜ Dry spoon in between sips** **⬜ Alternate food and liquid** **Other (e.g: ice, carbonation etc):**
Positioning for feeding	
Oral Control Supports	**⬜ Head support ⬜ Jaw support ⬜ Chin/lip support**
Risk for aspiration on	**⬜ Thin liquid ⬜ Thickened liquid ⬜ Thin puree ⬜ Thick puree**
Thickening Information	**⬜ Mildly thick ⬜ Moderately thick** **Thickener Dosage:(amount of thickener to volume of liquid)** **Thickener Instructions:**
Risk for reflux	**⬜ Yes ⬜ No**
Reflux Protocol after feeding	**⬜ Yes ⬜ No** **If yes, for how long:**

SIGNS OF ASPIRATION IN MY CHILD

⬜ coughing ⬜ wheezing ⬜ respiratory distress ⬜ chronic chest congestion ⬜ choking ⬜ sounding wet and gurgly ⬜ gagging ⬜ frequent chest infection ⬜ history of pneumonia

SIGNS OF REFLUX IN MY CHILD

⬜ gagging ⬜ vomiting ⬜ arching the body ⬜ grimacing ⬜ burping ⬜ hiccuping ⬜ throat clearing or coughing

Other:

ADMINISTRATION OF MEDICATION VIA G-TUBE:

Medication required through enteral tube	**⬜ N/A ⬜ YES** **If yes, refer to the MM.02-01 Administration of Prescribed Medication Form**

Directions/ Modifications for administration of medications

Amount of flush before or after medication: **Additional notes:**

TUBE FEEDING ROUTINE:

Primary form of nutrition	⬜**Formula: _____** ⬜**Blend**
Feed Method of Delivery	⬜**Pump** ⬜**Bolus** ⬜**Gravity**
Time, volume, and rate of tube feeds, including flushes	

MANAGEMENT PROCEDURE IN THE EVENT THE TUBE COMES OUT:

In the event of g-tube concerns (e.g: g-tube dislodged), School Nurse can replace G-tube if consent is obtained.

Please indicate with an X whether the replacement ⬜ G-tube OR ⬜ foley catheter, of same size or smaller, is kept ⬜ at school OR ⬜ travels with the student. Please include water soluble lubricant, obturator if needed, and a syringe for inflating the feeding tube balloon.

Additional Notes:

KETOGENIC DIET

Please provide specific information about dietary needs including time and amount of food and MCT oil dosage:

I/We authorize the Principal or Principal Designate to share the Plan of Care with school staff who are in direct contact with my/our child. (This may include: the classroom teacher, educational assistants, rotary teachers, occasional staff, appropriate Holland Bloorview Kids Rehabilitation Hospital staff).

Other individuals to be contacted regarding Plan of Care:_____

This plan remains in effect for the school year and will be reviewed annually. It is the parent's responsibility to notify the school team if there is a need to change the Plan of Care during the school year.

It is understood that copies of this Plan of Care will be maintained in the Speech-Language Pathology Record, Medical Risk Binder and the Ontario Student Record. This information will be held in confidence and maintained securely in accordance with Ontario's privacy law called the Personal Health Information Protection Act (PHIPA).

Parent(s)/Guardian(s) Signature_____Date_____

Personal information contained in this form is collected pursuant to the Education Act and the Municipal Freedom of Information and Protection of Privacy Act. Questions about the collection and the use of this personal information should be directed to Human Resources at the Bloorview School Authority at 416-422-7042.

Rev. ~~September 2025~~

ANNUAL REVIEW:

School Year: _____ Parent Signature:_____ Date:_____

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By signing the Feeding Plan of Care, I/we acknowledge the information and procedures contained in the attached Plan of Care is current and remains in effect.