Dream • Learn • Grow
Bloorview
SCHOOL AUTHORITY

Place Student Photo Here

FEEDING PLAN OF CARE

School Year: _____

STUDENT INFORMATION

Student Name:	Date of Birth:
Ontario Education Number (OEN):	Age:
Grade:	Teacher:

EMERGENCY CONTACTS (list in priority and best way to reach them)

Name	**Relationship** (parent/guardian must be first)	**Daytime Phone/Email**	**Alternate Phone**
1.			
2.			
3.			

RELATED MEDICAL CONDITIONS:

Any other medical conditions (e.g., reflux, seizures) or allergies?

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:

FEEDING MODIFICATION

NPO:	YES ☐ NO ☐
Safe for tastes:	YES ☐ NO ☐ If 'YES,' describe texture and amount:
Safe for oral feeds:	Smooth Puree ☐ Textured Puree ☐ Soft Food ☐ Table Food ☐
Safe for liquids:	Thin Liquids ☐ Thickened Liquids ☐ Describe any modifications:
Risk of aspiration on:	Thin Liquid ☐ Thickened Liquids ☐ Thin Puree ☐ Thick Puree ☐
Risk for reflux:	YES ☐ NO ☐

ORAL FEEDING ROUTINE

☐ Student is dependent for feeding
☐ Student feeds independently but requires close supervision for feeding and/or drinking
☐ Student requires monitoring after feeding

Modifications required prior to feeding:	
Positioning for feeding:	
Feeding method (head position, jaw support):	
Feeding modification (dry swallow, small spoon, single sip, pacing, etc.):	

SIGNS OF ASPIRATION IN MY CHILD

Coughing ☐ Wheezing ☐ Respiratory Distress ☐ Chronic Chest Congestion ☐ Sounding Wet and Gurgly ☐
Choking ☐ Gagging ☐ Frequent Chest Infection ☐ History of Pneumonia ☐

PLAN OF CARE IF ASPIRTATION IS SUSPECTED:

Before a meal: During a

meal:

After a meal:

SIGNS OF REFLUX IN MY CHILD

Gagging ☐ Vomiting ☐ Arching the Body ☐ Throat Clearing or Coughing ☐
Burping ☐ Hiccupping ☐ Grimacing ☐

Medication required prior to feeding: ☐ Administration of Medication Form Completed	N/A ☐ Name of medication: Dosage: Time of administration:
Positioning after feeding (reflux precautions):	

PLAN OF CARE IF REFLUX IS SUSPECTED:

Before a meal: During a

meal:

After a meal:

TUBE FEEDING ROUTINE

Name of formula:	
Amount of formula to be provided:	
Start time:	
Run time:	
Disconnect time:	
Feed delivery method:	Pump - Bolus - Gravity
Pump rate:	
Bolus instructions:	
Special priming notes:	
Amount of water flush:	Before meal: After meal:
Timing of flush:	Before meal: After meal:
Additional notes/precautions:	

ADMINISTRATION OF MEDICATION VIA G-TUBE

☐ Administration of Medication Form Completed	
Name of medication:	
Dosage:	
Time of administration:	
Method of administration (flush before or after, port used)	

PLAN OF CARE IN THE EVENT THE PUMP MALFUNCTIONS

In the event of g-tube concerns (for example g-tube dislodges) parents will be notified as they will need to take their child for medical attention

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. For example, the classroom teacher, educational assistants, rotary teachers, occasional staff, appropriate Holland Bloorview Kids Rehabilitation Hospital staff, and volunteers.

Other individuals to be contacted regarding Plan of Care: _____

This plan remains in effect for the completion of the school year and will be reviewed annually. It is the parent's responsibility to notify the principal 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 confidentially maintained in the Speech-Language Pathology Record, Medical Risk Binder, 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).

_____ _____

Health Care Provider Signature Date

Healthcare provider may include: Physician, Nurse Practitioner, Dietician, Feeding Clinic team member.

_____ _____

Parent(s)/Guardian(s) Signature Date

For office use only: Date reviewed: Speech-Language Pathologist:_____ Principal: _____
Names of trained individuals who will provide feeding support oral or g-tube:
1.
2.
Backup:

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.