Date of Plan: _____/_____/_____

Enteral Medical Management Plan

This plan should be completed by the student's medical team and parents/guardian. It has been created with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained personnel, and other authorized personnel.

Student's Name: _____
Date of Birth: _____/_____/_____ Initiation of Nutrition Therapy: _____
School Year: _____ Grade: _____ Homeroom Teacher: _____

Contact Information
Mother/Guardian: _____
Address: _____
Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____
Address: _____
Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider: _____
Address: _____
Telephone: _____ Emergency Number: _____

Other Emergency Contacts:
Name: _____
Relationship: _____
Telephone: Home _____ Work _____ Cell _____

Conditions under which parents wish to be contacted by the school _____
_____

Feeding Pump Information
Type of Pump Used _____ Rate of Infusion_____
Duration of Infusion _____ Start Time_____ End Time_____
Formula Infused Type _____ Amount _____
Can student hook up infusion independently? ☐ Yes ☐ No
Exceptions: _____
Procedures for Hooking Up and Disconnecting: _____
_____
Type and Size of Gastric Tube_____ Amount of Water in Balloon_____

Medications:
Name of Medication_____ Dose_____
Route of Administration_____

Name of Medication_____ Dose_____
Route of Administration_____

Parents are authorized to adjust the infusion rate under the following circumstances:

_____

_____

Student Pump Abilities/Skills:

	Needs Assistance	
Set Rate	☐ Yes	☐ No
Connect pump	☐ Yes	☐ No
Administer bolus	☐ Yes	☐ No
Change batteries	☐ Yes	☐ No
Disconnect pump	☐ Yes	☐ No
Reconnect pump and infusion set	☐ Yes	☐ No
Troubleshoot alarms and malfunctions	☐ Yes	☐ No

Supplies to Be Kept at School:

_____backup pump and batteries
_____gloves, etc.
_____extra feeding bags and syringes
_____formula
_____extra g-tube
_____change of clothes

This Individual Health Plan has been approved by:

_____ _____

Student's Physician/Health Care Provider Date

I give permission to the school nurse, and other designated staff members of _____ school to perform and carry out the enteral tasks as outlined by _____'s Individual Health Plan. I also consent to the release of the information contained in this Individual Health Plan to all staff members and anyone who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian Date

_____ _____

Student's Parent/Guardian Date