

**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 \_\_\_\_\_

