



# FREEDOM AREA SCHOOL DISTRICT

Freedom Area School District  
**Health Services**  
 Katie Winkler, RN District Nurse  
 Phone: 920-788-7944  
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Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Grade: \_\_\_\_\_

**Health Condition: Tube Feeding Action Plan and Medication Consent**

**Type of Nourishment:** \_\_\_\_\_

**Method of Feeding:** \_\_\_\_\_ Gravity \_\_\_\_\_ Push \_\_\_\_\_ Pump (Please name type of pump) \_\_\_\_\_

**Type of Tube/Size:** \_\_\_\_\_

**Venting Required:** \_\_\_ Yes \_\_\_ No **Frequency:** \_\_\_\_\_

**Residual Checks:** \_\_\_ Yes \_\_\_ No

- **HOLD FEEDINGS** if residual is more than \_\_\_\_\_ cc
- **Subtract residual volume from feeding volume** if residual is between \_\_\_\_\_ - \_\_\_\_\_ cc

**1st Feeding:**

Time: \_\_\_\_\_ Amount: \_\_\_\_\_ Rate: \_\_\_\_\_ Flush after feeding: \_\_\_\_\_

**2nd Feeding:**

Time: \_\_\_\_\_ Amount: \_\_\_\_\_ Rate: \_\_\_\_\_ Flush after feeding: \_\_\_\_\_

**3rd Feeding:**

Time: \_\_\_\_\_ Amount: \_\_\_\_\_ Rate: \_\_\_\_\_ Flush after feeding: \_\_\_\_\_

If a feeding is scheduled around lunch time, should it be given on early release day? \_\_\_ Yes \_\_\_ No

Water to be given between feedings: \_\_\_ No \_\_\_ Yes If so, Time(s) \_\_\_\_\_ and Amount: \_\_\_\_\_

**Medications to be mixed/given with feeding:** \_\_\_ No \_\_\_ Yes (if yes, will need a medication form completed)

**Position during Feeding:** \_\_\_\_\_ **Position after Feeding:** \_\_\_\_\_

**Order Requirements:**

- **A new order is required for each school year and/or when a change has been made to the procedure.**
- **Parents/Guardian will give instructions and demonstrations prior to the first feeding in school.**
- **Parents/Guardian will provide all supplies including nourishment, extension tubes, and syringes at school.**
- **Staff will complete the daily medication log after each feeding.**
- **If the tube comes out, the parent/guardian will be called. FASD staff will NOT reinsert it.**

**Medication Consent:** I hereby give permission to designated trained school personnel to give medications to my student during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold Freedom Area School District employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

**Students' health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff, and other pertinent FASD staff.**

**By signing you agree you have reviewed this health plan for your student and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.**

Parent's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Name (print): \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician's NPI Number: \_\_\_\_\_