**Nutrition and Feeding Care Plan**

The nutrition and feeding care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on a child’s diet and feeding needs for this child while in child care.

**Name of Child:** ____________________________________________  **Date:** ______________________

**Facility Name:** ______________________________________________________________________________________

**Team Member Names and Titles** (parents of the child are to be included)

**Care Coordinator** (responsible for developing and administering Nutrition and Feeding Care Plan):

__________________________________________________________________________________________________________________________________________

- If training is necessary, then all team members will be trained.

- Individualized Family Service Plan (IFSP) attached

- Individualized Education Plan (IEP) attached

**Communication**

What is the team’s communication goal and how will it be achieved (notes, communication log, phone calls, meetings, etc.): ____________________________________________________________

How often will team communication occur:  □ Daily  □ Weekly  □ Monthly  □ Bi-monthly  □ Other ________________

Date and time specifics: __________________________________________

**Specific Diet Information**

- Medical documentation provided and attached:  □ Yes  □ No  □ Not Needed

Specific nutrition/feeding-related needs and any safety issues: __________________________________________________________

- Foods to avoid (allergies and/or intolerances): _____________________________________________________

Planned strategies to support the child’s needs: __________________________________________________________

Plan for absences of personnel trained and responsible for nutrition/feeding-related procedure(s): __________________________________________________________

- Food texture/consistency needs: __________________________________________________________

- Special dietary needs: __________________________________________________________

- Other: __________________________________________________________

**Eating Equipment/Positioning**

- Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided  □ Yes  □ No  □ Not Needed

Special equipment needed: __________________________________________________________

Specific body positioning for feeding (attach additional documentation as necessary): __________________________________________________________
Behavior Changes (be specific when listing changes in behavior that arise before, during, or after feeding/eating)

Medical Information

☐ Information Exchange Form completed by Health Care Provider is in child’s file onsite.

☒ Medication to be administered as part of feeding routine:  Yes ☐ No

☐ Medication Administration Form completed by health care provider and parents is in child’s file on-site (including type of medication, who administers, when administered, potential side effects, etc.)

Tube Feeding Information

Primary person responsible for daily feeding: __________________________

Additional person to support feeding: __________________________

☐ Breast Milk ☐ Formula (list brand information): __________________________

Time(s) of day: __________________________

Volume (how much to feed): __________________________ Rate of flow: __________________________ Length of feeding: __________________________

Position of child: __________________________

☐ Oral feeding and/or stimulation (attach detailed instructions as necessary): __________________________

Special Training Needed by Staff

Training monitored by: __________________________

1) Type (be specific): __________________________

Training done by: __________________________ Date of Training: __________________________

2) Type (be specific): __________________________

Training done by: __________________________ Date of Training: __________________________

Additional Information (include any unusual episodes that might arise while in care and how the situation should be handled)

________________________

________________________

Emergency Procedures

☐ Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: __________________________

________________________

Emergency contact: __________________________ Telephone: __________________________

Follow-up: Updates/Revisions

This Nutrition and Feeding Care Plan is to be updated/revised whenever child’s health status changes or at least every ____ months as a result of the collective input from team members.

Due date for revision and team meeting: ______________