

# **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*): \_\_\_\_\_

\_\_\_\_\_

① 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)

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**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)

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**Emergency Procedures**

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

Emergency instructions: \_\_\_\_\_

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Emergency contact: \_\_\_\_\_    Telephone: \_\_\_\_\_

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**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: \_\_\_\_\_