Nutrition and Feeding Health 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 the child’s diet and feeding needs 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 the 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
How the team will communicate (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 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: ________________________________________________________________________________

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 on site: ☐ Yes ☐ No
- Medication to be administered as part of feeding routine: ☐ Yes ☐ No
- Medication Administration Form completed by health care provider and parents are in child’s file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.) ☐ Yes ☐ No

Tube Feeding Information

Primary person responsible for daily feeding: ______________________________________________________
Additional person to support feeding: ____________________________________________________________
☐ Breast ☐ 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 Staff Training Needs

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: ________________________________________

Resources:
California Childcare Health Program. www.ucsfchildcarehealth.org
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