Holly Area Schools

Tube Feeding Log

Student's Name: ________________________________ School Year :__________________
Date of Birth: ________________ School/Program: __________________________________
Age: ___________ Grade: _____________ Teacher: _________________________________
Type of Tube: _________________________ Formula Name: __________________________
Method of feeding: ☐ Gravity ☐ Bolus Feeding Amount: ___________________________
Time: _____________ Free water: ☐ Yes ☐No Amount: ____________
Check Residual: ☐Yes ☐No If residual above ______ ml, hold for ___________ minutes
Remain upright x 30min: ☐Yes ☐No Oral Intake allowed: ☐Yes ☐No

Date	Time Started	Time Finished	TF amount Given	Water amount Flushed	Oral Amount %	Tolerated w/o Incident	Initials
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

4/2024

* If administering tube feeding, signature must be present on form.

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Student Name: ____ Date of Birth: ___________________

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Staff Signature	Staff Initials	Date

4/2024

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