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 Amount: _____
Time: ☐ AM _____ ☐ PM _____ Check Residual: ☐Yes ☐No
If residual above _____ ml, hold for _____ minutes
Free water: ☐ Yes ☐No Amount: _____ Remain upright x 30min: ☐Yes ☐No
Oral Intake allowed: ☐Yes ☐No If yes, what is allowed:_____

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	

4/2022

Holly Area Schools

Tube Feeding Log

Student Name: _____ Date of Birth: _____

Date	Time Started	Time Finished	Amount Given	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	

Staff Signature	Staff Initials	Date