Nursing Feeding Assessment

Student:_____Date:_____

Parent concerns:_____

_____

Medical History

Diagnosis: _____

Medication: _____

Allergies: Y ❑ N ❑ If yes, list _____

_____

_____

Asthma Y ❑ N ❑

Pneumonia Y ❑ N ❑ If yes, list _____

_____

Reflux Y ❑ N ❑

G-Tube Y ❑ N ❑

Feeding evaluation Y ❑ N ❑ If yes, where/when _____

_____

Swallow study Y ❑ N ❑ If yes, where/when _____

_____

History of choking Y ❑ N ❑ If yes, Heimlich required Y ❑ N ❑

Breath Sounds: With stethoscope Y ❑ N ❑

Before Food _____ After Food _____

Before Liquid _____ After Liquid _____

Comments:_____

_____

_____

_____

_____

Nurse:_____

School:_____Email:_____