Cherokee County School District

Physician's Order for Oral Feeding

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Oral Feeding Orders (to be completed by physician):

_____NPO: Nothing by mouth

_____ Oral feeding as indicated below

Food:			**Liquids:**	
Check one			Check one	
	Regular Diet			Thin liquids
	Chopped Foods			Nectar consistency
	Soft foods			Honey consistency
	Pureed foods			Pudding consistency
	Other – please specify:			Other – please specify:

_____Other specific exclusions/orders _____

This order is to remain in effect for the 20__ to 20__ school year, unless there is a change in medical status.

_____ _____

Physician's signature Date

_____ _____

Physician's printed name Physician's phone number

I authorize the physician's office to release confidential information about my child to the Cherokee County School District.

_____ _____

Parent's signature Date

****Please return this form to the school with all pertinent feeding/swallowing records (e.g., occupational/speech therapy notes/evaluations, videofluoroscopic swallow study reports).**