Inspiring Excellence
LAKE STEVENS
School District

Lake Stevens School District | 12309 22nd St. NE | Lake Stevens, WA 98258-9500
425-335-1500 (office) | 425-335-1549 (fax)

DYSPHAGIA ANNUAL PHYSICIAN ORDER & INDIVIDUALIZED HEALTH CARE PLAN

Student Name:_____ Birthdate:_____

School:_____ Grade: _____

To Be Completed by the Parent or Legal Guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to provide treatment to the above identified student in accordance with the prescriptive authority's instructions for the period commencing with the _____ day of _____, 20 ___ to *either* the _____ day of _____, 20 ___ or to the end of the current school year, whichever is sooner. I understand and agree that because of schedule and other responsibilities, feedings or treatments may be delayed or missed.

Signature: _____Date:_____

Telephone number(s): _____

To Be Completed by a Licensed Health Professional with Prescriptive Authority

Has a swallow study been completed for this student? ☐ YES ☐ NO Date:_____
*If **YES**, please attach a copy of the swallow study completed within the last 12 months.*

Is a swallow study recommended/scheduled at this time? ☐ YES ☐ NO

Is the student considered safe at school for oral nutrition and /or hydration? ☐ YES ☐ NO

Food/Liquid Modifications Required *(Limited selection available at school if other than regular; parents may choose to provide additional foods/ liquids. Food/liquids provided by parents must be consistent with physician orders below.)*	
Food Texture: (Based on IDDSI. Select only one) ☐ NPO ☐ Level 3 (Liquidised) ☐ Level 4 (Pureed) ☐ Level 5 (Minced and Moist) ☐ Level 6 (Soft and Bite-sized) ☐ Level 7 (Regular/Easy to Chew) ☐ Level 7 (Regular, no restrictions) ☐ Other (please describe and provide detailed diet information) _____	Liquid Consistency: (Based on IDDSI. Select only one) ☐ NPO ☐ Level 4 (Extremely Thick) ☐ Level 3 (Moderately Thick) ☐ Level 2 (Mildly Thick) ☐ Level 1 (Slightly Thick) ☐ Level 0 (Thin, no restrictions) Student cleared for Transitional Foods, when at food textures 5-7 (e.g. cheese puffs, graham crackers, etc.) ☐ Yes ☐ No

Need for Assistance:	Please Indicate if the following are present:	
☐ Total assistance ☐ Self-feeding with assistance ☐ Supervision ☐ Independent	☐ Food Allergies ☐ Feeding Tube: type_____ ☐ Trach/Trach History ☐ Wheelchair ☐ Cleft Palate	List All Known Food Allergies / Medication(s) Affecting Student's Swallow: _____ _____

Dysphagia:	Prognosis for Independent Oral Feeding:	Risk of Aspiration:
☐ Oral Phase ☐ Oropharyngeal Phase ☐ Pharyngeal Phase ☐ Pharyngoesophageal Phase ☐ Esophageal Phase ☐ Other _____	☐ Good ☐ Fair ☐ Guarded ☐ Poor	☐ High ☐ Moderate ☐ Low ☐ None

DYSPHAGIA ANNUAL PHYSICIAN ORDER & INDIVIDUALIZED HEALTH CARE PLAN (Cont.)

Student Name:_____ Birthdate:_____

School:_____ Grade: _____

Feeding Procedures:		
Procedures	Equipment Required	Positioning
☐ Sit upright at 90 degrees ☐ Tuck chin downward during swallow ☐ Turn head left/right during swallow (please indicate direction) ☐ Alternate solids and liquids ☐ Minimize distractions within environment ☐ Cue to slow down rate of eating or drinking ☐ Take small bites, small sips, less than 1 teaspoon at a time ☐ Do not take food or liquids while coughing (stop eating; encourage coughing; wait at least 1 minute) ☐ Check mouth or left/right cheek(s) for pocketing ☐ Listen for wet vocal quality after swallow (cue to clear throat and swallow if needed) ☐ Remain upright _____ minutes after eating ☐ Other (please describe)		

I request and authorize that the above named student be provided the above identified treatment in accordance with the instructions indicated above for the period commencing with the _____ day of___, 20 _____ through the _____ day of _____ , 20 ____, or to the end of the current school year, whichever is sooner, as there exists a valid health reason which makes provision of the treatment advisable during school hours or during such time that the student is under the supervision of school officials. Such treatments/feedings may be administered by school personnel who have no formal medical education.

_____ Signature: _____

Date of Signature (Licensed Health Professional with Prescriptive Authority)

Telephone: _____ Name: _____

(Print or Type)

Please return the completed form to:

_____

School Nurse

Building: _____

Address: _____

_____

Phone: _____

Fax: _____

For School Use Only

Team Members

Nurse_____

Nutrition_____

OT_____

PT_____

SLP_____

Teacher_____

For School Nurse Use Only

- ☐ Upload to Skyward
- ☐ Complete Emergency Care Plan
- ☐ Distribute to team- Physician Orders, ECP, diet/liquid lists
- ☐ Provide ECP to Transportation
- ☐ Training completed- provide Staff Approved list to teacher, and keep a copy in the student's health room file
- ☐ For students transitioning to a new school the next school year, School Nurse to contact nurse at new school in the spring