REQUEST FOR LICENSED HEALTHCARE PROVIDER FEEDING ORDERS

Student Name: _____ DOB: _____ School Year: 2023-2024

Dear Parent(s)/Guardian(s) and Licensed Healthcare Provider:

To ensure safe school feeding, adequate nutrition and hydration, we request that you complete, sign and return the information below. This information will be handled in a confidential manner and can serve as a medical action plan (MAP) for feeding. All orders will need to be complete and align with safe and legal school interventions. Please note that snacks and feedings are scheduled. Although, timing and other accommodations can be implemented for inclusivity. **Authorization is valid for one school year only.**

Please check and fill in ALL that apply:

The following diet/feeding instructions/accommodations/restrictions are needed for this student at school:

☐ Independent
☐ Assisted
☐ Dependent
☐ Nothing by mouth
☐ Foods to avoid due to allergies/sensitivities: _____
☐ Student may perform self-feeding, and may need assistance with the following: _____
_____
☐ Other instructions: _____

☐ Liquid
- ☐ No restrictions
- ☐ No thin liquids
- ☐ Nectar consistency liquids
- ☐ Honey consistency liquids
- ☐ Ultra thick liquids (pudding consistency)
- ☐ Thin liquids
  - ☐ Amount, type of cup and instructions: _____
- ☐ Thickener
  - ☐ Amount of thickener per amount of liquid: _____

☐ Solid food
- ☐ No restrictions
- ☐ Pureed
- ☐ Chopped
- ☐ Soft
- ☐ Mashed
- ☐ Bite size
- ☐ Moist
- ☐ Other food restrictions: _____
- ☐ Nutritional supplements
  - ☐ Type: _____
  - ☐ Amount: _____
  - ☐ Time(s) of day: _____

☐ Tube Feeding/Hydration:

- ☐ Gastrostomy (G) ☐ Gastrojejunal (GJ) ☐ Jejunal (J)
- ☐ Nasogastric (NG) ☐ Nasoduodenal (ND) ☐ Nasojejunal (NJ)
- ☐ Product name: _____
- ☐ Pump Feed; Type of Pump and which port: _____
  - ☐ Amount; Stop time (mL/hr): _____
    OR
  - ☐ Amount; Continuous feed (mL/hr)
  - ☐ Additional instructions: _____
- ☐ Bolus feed; ☐ Push ☐ Gravity
  - ☐ Amount: _____
  - ☐ Over how many minutes: _____
  - ☐ Additional instructions: _____
- ☐ Flush rate and when: (pump or bolus): _____
- ☐ Fluid bolus; ☐ Push ☐ Gravity
  - ☐ Type of fluid: ☐ Water ☐ Other: _____
  - ☐ Temperature of fluid: ☐ Tap cold ☐ Room temperature ☐ Other: _____
  - ☐ Amount (mL) and when: _____
- ☐ Tube and oral feed
- ☐ Action required in case the tube is dislodged or falls out: **See RCS protocol**
- ☐ Student may perform self-care with tube feeding and/or tube placement

☐ Procedures:

- ☐ Amount of food per bite (Ex. ½ teaspoon, size of a goldfish): _____
- ☐ Wait time (Allow time for student to swallow multiple times between bites, ex. One bite at a time):
  _____
- ☐ Behavior techniques (Ex. Redirection for fatigue/irritability) _____
- ☐ Student's communication or signals during feeding (Ex. Visual and tactile aids): _____
- ☐ Avoid traditional choking hazard shapes, textures and sizes
- ☐ Food placement (Ex. Direct to mouth): _____

☐ Positioning:

- ☐ Sitting posture (For ex. Upright): _____
- ☐ Chair/Seating Device (Ex. Personal wheelchair, tomato chair): _____
- ☐ Head position/support (Ex. Midline): _____
- ☐ Trunk control (Ex. Harness): _____

Licensed Provider Name: _____
Hospital/Clinic Name: _____
Address: _____
Suite: _____
City/State/Zip Code: _____
Phone Number: _____
Fax: _____

(Provider Stamp)

Health Care Provider Signature: _____ Date: _____

Parent Name: _____ Signature: _____Date: _____