



Health Care Provider Authorization and Recommendations for Assisted Oral Feedings

Student's name: _____ Birthdate: _____
School: _____ Grade: _____
Student's diagnosis: _____ Allergies: _____

This is to certify that the above-named student is under my care and needs to receive oral feedings during school hours as ordered below. I understand that some of these feedings may be administered by medically unlicensed school staff that will be trained and monitored by a school nurse. (*Note: If student is also receiving assisted gastrostomy or gastrojejunostomy feedings, please complete both provider forms for the school - #5335.02 F1 and #5335.02 F2.)

1. SWALLOW STUDY AND EVALUATION INFORMATION

Has this student had a recent swallow study? Yes _____ No: _____
If yes, please send a copy of the test results or summarize as follows: Date of study: _____
Results: _____
If no, will this student be referred for a future swallow study and evaluation? Yes _____ No: _____
If yes, study is scheduled on _____.

2. CLARIFICATION OF ASPIRATION RISK WITH ORAL FEEDINGS (Please check all that apply)

LOW or no aspiration risk HIGH aspiration risk
 OK to orally feed at school Do NOT orally feed at school

3. ORDERS FOR FEEDING AT SCHOOL TO INCLUDE (Please check all that apply)

- **Position of student during feeding, and after feeding (for _____ minutes):**
 - Sit upright Head elevated to ____ degrees Feet supported
 - Posture alignment In chair Other (specify) _____
- **Level of assistance required:**
 - Independent Moderate assist Dependent
 - Minimal assist Maximum assist
- **Food Texture & Drink Thickness**
 - Regular / easy to chew (7 IDDSI) Mildly thick (2 IDDSI)
 - Soft and bite-sized (6 IDDSI) Slightly thick (1 IDDSI)
 - Minced and moist (5 IDDSI) Thin (0 IDDSI)
 - Pureed/extremely thick (4 IDDSI) Other: _____
 - Liquidized/moderately thick (3 IDDSI)
- **Recommended amounts of oral food or drink per bite/sip:**
 - Pinched straw sip Sippy cup / controlled flow 1/4 tsp per bite
 - Continuous straw sip Open cup 1/2 tsp per bite
 - Other: _____ 1 tsp per bite
 - _____ > 1 tsp per bite
- **Recommended feeding strategies for food/drink**
 - Chin tuck Turn head to L/R Alternate liquids and solids Tongue sweep to clear oral cavity
 - Support under chin Cough/throat clear Repeat cued swallow Scissor technique
 - Other: _____
- **Adaptive equipment**
 - Modified bowl _____ Adaptive cup (specify) _____
 - Modified spoon _____ Other (specify) _____
 - Modified fork _____
- **Other precautions, limitations, relevant medical or dietary information (ex.: water only, 0 gelatin, gluten free, etc.)**

Beginning date for order: _____ Ending date for order: _____

Prescriber's signature: _____ Office #: _____

Prescriber's printed name: _____ Fax #: _____

Office address: _____

Parent/guardian signature: _____ Date: _____