MEDICAL PERMISSION TO ADMINISTER ORAL FEEDING

Student Name: _____ Student Number: _____
Date of Birth: _____ School: _____
Diagnosis: _____ ICD-10 code: _____

Dear Provider,
The student, _____, has demonstrated symptoms during oral feeding that indicate potential risk such as, but not limited to, reflux, delayed swallow, abnormal gag reflex, poor saliva management, choking, coughing or other signs of difficulty while eating. Additionally, this student may have a history of respiratory problems possibly related to aspiration of secretions, foods, or liquids.

Prior to any oral feeding of this student at school, parent and provider authorization and the oral feeding instructions are required (see below). For non-oral feeding orders, complete the Authorization to Administer Feeding thru a G-Tube.

Does this student have a swallowing problem? ☐ YES ☐ NO If yes, please explain the problem:

_____

_____

_____

_____

Has the student had a swallow fluoroscopy and/or FEES done? ☐ YES ☐ NO If yes **date of the study?** _____. Please include a copy of the study results.

Is there a health professional working on swallowing issues with this student? ☐ YES ☐ NO

If yes, please provide the name and contact information for this individual:

_____

School personnel are authorized to orally feed ☐ YES ☐ NO
(If yes oral feeding instructions must be attached)
Oral feeding instruction provided by: ☐Provider ☐ Parent ☐ Other (specify) _____

Provider Signature: _____ **Date:** _____
Provider Name (Please Print): _____
Address: _____
Phone: _____ Email: _____

Parent/Guardian Signature: _____ **Date:** _____

Oral Feeding Instructions completed and attached? ☐ YES ☐ NO

Oral feeding of the student by school personnel will NOT be accomplished without these orders & instructions

ORAL FEEDING INSTRUCTIONS

These Oral Feeding Instructions and the Medical Permission to Administer Oral Feeding MUST be completed before the student will be orally fed at school by any school personnel.

Student Name: _____ Student Number: _____
Date of Birth: _____ School: _____
Diagnosis: _____ ICD-10 code: _____

FOOD ALLERGIES: _____

Frequency of feedings during the school day: _____

Amount of liquid required between meals: _____

Environmental considerations during each feeding (circle all that apply):

Low lighting With peers Without peers

Other: _____

Positioning during feeding (circle all that apply):

Fully upright W/C Reclined 10 to 20 degrees W/C Reclined 30 to 45 degrees

Chair postural supports Other: _____

Food consistency (circle all that apply):

Regular cafeteria tray Soft foods Pureed foods

Other: _____

Liquid consistency, (specify liquid, amount, etc) (thickeners to be supplied by parent/guardian):

Thin liquid Thickened:

_____

_____

Volume/size of bolus (specify amount of liquid or solid offered per bite): _____

Techniques recommended to assist in oral swallowing: _____

_____

Adaptive equipment (circle all that apply): adaptive cup adaptive spoon

Other: _____

Other precautions, modifications, or recommendations: _____

_____

Please specify any supplementation, amount of supplementation, and when it is to be provided: _____

Does the student have a tracheostomy? ☐ YES ☐ NO (Tracheostomy tube cuff should be deflated during the feeding)

SLP/Feeding Therapist Signature: _____ Date: _____

Therapist Name (Please Print): _____

Address: _____

Phone: _____ Email: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Please Print): _____

Address: _____

Phone: _____ Email: _____

Oral feeding instructions received reviewed by_____ Date: _____
School staff representative/School Nurse signature