Dublin City School District

Students
5335.02 F1
Revised 6/27/19

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):**
  ☐ Upright ☐ Head elevated to ____ degrees ☐ Other (specify) _____
- **Level of assistance required:**
  ☐ Independent ☐ Moderate assist ☐ Dependent
  ☐ Minimal assist ☐ Maximum assist
- **Food/Drink Consistency/Texture**
  ☐ Regular ☐ Mildly thick liquid
  ☐ Soft and bite-sized ☐ Slightly thick liquid
  ☐ Minced and moist ☐ Thin liquid
  ☐ Pureed/extremely thick liquid ☐ Other: _____
  ☐ Liquidized/moderately thick liquid
- **Recommended amounts of oral food or drink per bite/sip:**
  ☐ Pinched-straw sip ☐ Sippy cup ☐ 1/2 tsp per bite
  ☐ Continuous straw sip ☐ Cup drink ☐ 1 tsp per bite
  ☐ Other: _____ ☐ > 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 ☐ Other: _____
- **Adaptive equipment**
  ☐ Modified bowl _____ ☐ Adaptive cup _____
  ☐ Modified spoon _____ ☐ Other (specify) _____
  ☐ Modified fork _____
- **Other precautions, limitations, relevant medical or dietary information:**
  _____
  _____

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

Provider's signature: _____ Office #: _____
Provider's printed name: _____ Fax #: _____
Office address: _____

Parent/guardian signature: _____ Date: _____