Oral Feeding - Nutrition Information

Student Last Name	Student First Name	Birthdate	Gender	Allergies
			□ Male □ Female	
Parent/Guardian Name		**Parent / Guardian Phone Number**		
Physician Name		**Physician Phone Number**		

PART A

Does the child receive nutrition via g-tube or j-tube? ☐ Yes ☐ g-tube ☐j-tube ☐ No
If **YES,** complete the Nutrition Information Tube feeding form

Does the child have any special nutritional or feeding needs? ☐ Yes ☐ No
If **YES,** complete **part B** and have it signed by **physician**
If **NO,** parent/guardian may sign this form and return to school without physician signature

PART B- ***Complete only if your child has special nutritional or feeding needs.***

Dietary restrictions	☐ YES (specify restrictions) _____ ☐ NO
Level of assistance needed	☐ Full ☐ Hand over hand ☐ Supervise ☐ Independent
Recent swallow study	☐ Yes Date of study_____ Results_____ ☐ No

ASPIRATION RISK WITH ORAL FEEDINGS
☐ LOW or no aspiration risk ☐ HIGH aspiration risk

POSITIONING DURING FEEDING
Position of student during feeding and after feeding for _____ minutes:
☐ Upright ☐ Wheelchair ☐ Other _____

RECOMMENDED FEEDING STRATEGIES
☐ Support under chin ☐ Turn head to L/R ☐ Chin tuck
☐ Other _____

ADAPTIVE FEEDING EQUIPMENT NEEDED
☐ adaptive bowl ☐ adaptive spoon
☐ Other _____

FOOD CONSISTENCY/TEXTURE
☐ Pureed
☐ Casserole/ground meat
☐ Mechanical soft
☐ Regular (includes raw vegetables & chips)
☐ Other _____

DRINK CONSISTENCY/ TEXTURE
☐ NO liquids
☐ Thin liquids
☐ Thick liquids
☐ Other _____

RECOMMENDED AMOUNTS OF ORAL FOOD AND DRINK PER BITE/SIP
☐ ½ tsp per bite ☐ 1 tsp per bite
☐ Straw ☐ Sippy Cup
☐ Other _____

Other relevant medical or dietary information:

Physician Signature_____ **Printed Name** _____ **Date**_____

I hereby request and give my permission for MDS nurse to administer the above-stated feeding to my child. I agree to submit a revised nutrition information form if anything changes and annually as required. I understand I must provide all the necessary equipment, supplies, and formula for my child's feeding.

Parent/Guardian Signature _____**Printed Name** _____**Date**_____

Marklund Day School Geneva
1S376 Wyatt Drive, Geneva, IL 60134
630.953.5300 | 630.397.5624 fax