

REQUEST FOR PHYSICIAN FEEDING SAFETY ORDERS

Student: _____ DOB: _____

Dear Doctor: To ensure safe feeding and adequate nutrition for this child at school, I request that you complete and return the information below. Please call if you have any questions or concerns. Thank You.

School Nurse: _____

FEEDING SAFETY FOR SCHOOL

The following diet/feeding modifications are needed for this child at school:

- No Restrictions
- Nothing by mouth
- Liquid food restriction:
 - No thin liquids
 - Nectar consistency liquids
 - Honey consistency liquids
 - Ultra thick liquids
 - Other: _____
- Thickener recommended: _____
 - Type Recommended: _____
 - Amount of thickener per amt. of liquid: _____
- Solid food restrictions due to dysphagia: _____
- Foods to avoid due to allergies/sensitivities: _____
- Nutritional Supplement:
 - Type: _____
 - Amount: _____
 - Time(s) of Day: _____
- Gastrostomy Tube Feeding:
 - Formula Name: _____
 - Amount: _____
 - Time(s): _____
 - Bolus Feedings by gravity? _____
 - Amount of water to give after bolus feeding: _____
 - If feeding pump is used, what are the settings? _____
- Other dietary or feeding safety advice: _____

PHYSICIAN SIGNATURE: _____ Date: _____

PARENT SIGNATURE: _____ Date: _____