



Physician / Parent Authorization for Feedings - Neurological Conditions

The School Nurse will review the order & ensure that it is completed & dated. Feedings will be provided when this form is completed in its entirety by both physician(s) & parent/guardian(s).

Student _____ ID# _____ DOB _____ Age _____ Grade _____

Teacher _____ Campus _____

Condition/Diagnosis: _____

Previous History: _____

Feeding Instructions:

Positioning: _____

Equipment: _____

Tube Feeding: Tube Feeding / Nothing By Mouth: _____ Tube and Fed Orally: _____
(Amount Fed Orally): _____

Diet / Food Preparation:

Food Consistency: Pureed _____ Ground _____ Chopped _____ Mashed _____ Bite Size _____

Liquid Consistency: No liquids _____ Thin liquids _____ Thickened liquids (circle): Nector Honey Pudding

Other: _____

Feeding Plan Techniques / Precautions:

Amount of food per bite: _____

Food Placement: _____

____ Keep student in upright position _____ minutes after meal(s)

____ Offer a drink after _____ bites

Additional Precautions / Comments: _____

Parent/Guardian Signature: _____ Date: _____

Address: _____

Phone # (Home): _____ (Work): _____ (Cell): _____

Physician Signature: _____ Date: _____

Address: _____

Phone #: _____ Fax #: _____