Division of Special Education and Special Services
Health Services Department

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: ____

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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:____

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Parent/Guardian Signature: ____ Date: _______________
Address: ____
Phone # (Home): ______________________ (Work): __________________ (Cell): _________________

Physician Signature: ____ Date: ______________
Address: ____
Phone #: ________________________________ Fax #: ____________________________

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