

Medical Permission To Administer Oral Feeding

Student Name: _____	Student Number: _____	DOB: _____
School: _____	Diagnosis: _____	
Parent/Guardian Name: _____	Phone: _____	

Medical Background:

This student may exhibit feeding-related risks (e.g., reflux, delayed swallow, abnormal gag reflex, poor saliva management, coughing, choking) and/or a history of respiratory concerns related to possible aspiration.

Does this student have a swallowing problem? ☐ YES ☐ NO

If yes, please explain: _____

Swallow study (fluoroscopy/FEES) completed? ☐ YES ☐ NO Date: _____ (Attach results)

Receiving services for swallowing? ☐ YES ☐ NO If yes, provider name/contact: _____

Authorization

School personnel may provide oral feeding: ☐ YES ☐ NO

If Yes: Instructions provided by: ☐ Provider ☐ Parent/Guardian ☐ Other: _____

Required: Oral Feeding Instructions must be completed and attached.

Date Form Completed: _____
Provider Signature: _____ Provider Name (Please Print): _____
Address: _____
Phone: _____ Email: _____

Parent/Guardian Consent

I authorize oral feeding at school as outlined. I agree to provide all required supplies, follow recommended care, and maintain communication with the student's healthcare provider(s) and school nurse regarding any changes in feeding status or medical condition.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Oral Feeding Instructions completed and attached? ☐ YES ☐ NO

(Oral feeding of the student by school personnel will NOT be accomplished without these orders & instructions)

Oral Feeding Instructions

Student Name: _____ Student Number: _____ DOB: _____
School: _____ Diagnosis: _____
Parent/Guardian Name: _____ Phone: _____

Health Conditions: _____ **Allergies:** _____

Feeding Schedule

Frequency: _____ Liquids between meals: _____

Environment: ☐ Low lighting ☐ With peers ☐ Without peers ☐ Other: _____

Positioning: ☐ Upright ☐ Reclined 10–20° ☐ Reclined 30–45° ☐ Supports / Other: _____

Food Consistency): ☐ Regular ☐ Soft ☐ Pureed ☐ Other: _____

Liquid Consistency: ☐ Thin ☐ Thickened (parent/guardian will provide thickener)

Details: _____

Volume/size of bolus (specify amount of liquid or solid offered per bite): _____

Techniques/Supports recommended to assist in oral swallowing: _____

Adaptive Equipment: ☐ Cup ☐ Spoon ☐ Other: _____

Other precautions, modifications, or recommendations: _____

Supplementation (if applicable): _____

Tracheostomy present? ☐ YES ☐ NO (If yes, cuff should be deflated during feeding)

Completed by SLP/Feeding Therapist/Healthcare Provider:

Date Form Completed: _____
Provider Signature: _____ Provider Name (Please Print): _____
Address: _____
Phone: _____ Email: _____

Authorization:

Parent/Guardian Signature

Date

Oral feeding instructions received reviewed by School Nurse:

School Nurse name/ signature

Date