PARK CITY SCHOOL DISTRICT

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: _____