**Maryland School for the Blind SY 2021-22**

**Parent or M.D.**

**NUTRITION ORDER**

**Student Name**:  **Date of Birth**: 

Does the student have any of the following nutritional needs/concerns?

● Food allergy YES [ ]  NO [ ]

● Food texture modification YES [ ]  NO [ ]

● Size modification of food morsels YES [ ]  NO [ ]

● Medical condition requiring special diet YES [ ]  NO [ ]

● Medical condition requiring NPO (nothing by mouth)

 orders and/or feeding by gastrostomy YES [ ]  NO [ ]

● History of aspiration and/or pneumonia YES [ ]  NO [ ]

● Any restrictions on liquids? YES [ ]  NO [ ]

 Thickened liquids required? YES [ ]  NO [ ]

If the answer to all of these questions is NO, please indicate Regular diet by signing below.

**Regular Diet/Special food request i.e., kosher, vegan, etc.**

Parent Signature Date

If any of the answers above are marked YES,

**PLEASE proceed to the next section and fill in specifics. Needs to be filled out and signed by a Physician.**

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Food allergy:

Texture required: □ Pureed (smooth, no lumps, and no chunks) □ Ground (has lumps, moist and finely chopped)

 □ Modified regular (Soft cooked vegetables, soft fruit, moist meats, easy to chew foods)

Size of food morsels: (1/8, 1/4, 1/2 inch)

Special diet:

Liquid restrictions:

Thickened liquid consistency:

□ Nectar □ Honey □ Preferred thickening product

□ NPO with gastrostomy □ Food by mouth with gastrostomy

**Please complete gastrostomy feeding order if this student has a GT.**

Physician Signature: Date:

PB/cic:5/27/21