

**SY 2023-2024 Nutrition Order**

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

Please answer ALL of the following questions related to your student’s mealtime needs.

If you answer YES to any of the following questions, please see additional forms/orders needed. **\*Physician signature may be required and is indicated below and on individual forms\***

|  |
| --- |
| **Does your student have any of the following nutritional/diet concerns?** |
| **1. Food Allergy- specific foods to avoid** | **NO** | **YES****(Fill out Form A)****\*Physician Signature Required\*** |
| **2. Special Diet Need- due to medical condition or preference****(i.e., vegan, vegetarian, low-sodium, Kosher, etc.)** | **NO** | **YES****(Fill out Form B)****\*Physician Signature Required for some\*** |
| **3. Food Texture Modification (e.g., puree/ground/thickened, etc.)** | **NO****(unmodified/Level 7 or 7a food- see definition on Form C and complete form accordingly)** | **YES   (Fill out Form C)****\*Physician Signature Required for all****levels except 7 & 7a\*** |
| **4. Liquid Thickness Modification (e.g., nectar thick liquid, honey thick liquid)** | **NO****(unmodified/Level 0 liquid- see definition on Form D and complete form accordingly))** | **YES   (Fill out Form D)****\*Physician Signature Required for all levels except Level 0 \*** |
| **5. Restrictions or special instructions related to liquid intake** | **NO** | **YES   (Fill out Form E)****\*Physician Signature Required\*** |
| **6. Safety Modifications for Mealtime (e.g., meal prep to cut food, monitor rate of intake, etc.)** | **NO** | **YES   (Fill out Form E)** |
| **7. Gastrostomy Tube (G-tube) Feeding Order** | **NO** | **YES   (Fill out Form F)****\*Physician Signature Required\*** |
| **8. Selective Eating Habits (extreme pickiness, limited food preferences)** | **NO** | **YES (Fill out Form G)** |
| **9. History of aspiration and/or pneumonia** | **NO** | **YES****(additional information may be requested at a later date)** |

**-1-**



**SY 2023-2024 Nutrition Order**

**Form A**

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

**Food Allergy Information**

**(i.e. specific foods, lactose or dairy, gluten, peanut, etc.)**

**Food Allergy:**

**Reaction:**

**Mealtime Needs in addition to avoidance of identified food (if needed):**

**Physician Signature: Date:**

**Physician Print Name: Date:**

**-2-**



**SY 2023-2024 Nutrition Order**

**Form B**

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

**Special Diet Information**

\*MSB’s Student Wellness Policy honors reasonable requests in the following categories. Please indicate the requirements of your student’s special diet. (Some requests may require you to send desired items to school with your child on a regular basis).

[ ]  **Religious/Cultural**

Requirement**:**

[ ]  **Lifestyle**

Requirement**:**

[ ]  **Nutritional \*see below- Health Provider Signature Required\***

[ ]  **Medical \*see below- Health Provider Signature Required\***

**Parent/Guardian Signature: Date:**

**Parent/Guardian Print Name:**

[ ]  **Nutritional**

 Requirement**:**

[ ]  **Medical**

Requirement**:**

**Physician Signature: Date:**

**Physician Print Name: Date:**

**-3-**



**SY 2023-2024 Nutrition Order**

**Form C**

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

**Food Texture Modification**

**\*Physician Signature Required\***

Please identify the following information to help us prepare your student’s food. If you have questions about which level your child’s diet fits into, please contact Sara Feazell, Supervisor of Speech & Language Services (saraf@mdschblind.org; 410-444-5000 x1337) by June 16, 2023.

**Food Texture- IDDSI Levels:**

[ ]  **Level 7: Regular:** Normal, everyday foods of various textures that are developmentally and age appropriate; ability to bite and chew without tiring for all foods required. *(no physician signature required for this level)*

[ ]  **Level 7a: Easy to Chew:** soft, tender texture of various foods; DO NOT use foods that are hard, tough, chewy, fibrous, have stringy textures, pips/seeds, bones or gristle; may include mixed thin/thick textures, must be able to bite and chew until safe to swallow without tiring. *(no physician signature required for this level)*

**Parent/Guardian Signature: Date:**

**Parent/Guardian Print Name:**

[ ]  **Level 6: Soft & Bite-sized:** pieces no bigger than 1.5cm x 1.5cm (adult) or 8mm x 8mm (pediatric); biting not required; chewing of bite sized pieces for safe swallow required; mashable with tongue or light pressure from fork.

[ ]  **Level 5: Minced & Moist:** no liquid dripping from food; biting not required; minimal chewing required; mashable with tongue or light pressure from fork; lumps 4mm size.

[ ]  **Level 4: Extremely Thick/Pureed:** usually eaten w/spoon; does not require chewing; smooth, not sticky; cannot be drunk from cup or sucked through straw.

**If you checked Level 4, 5, or 6, you must complete Form E for Supervision and Safety Modifications for Mealtime**

**Physician Signature: Date:**

**Physician Print Name: Date:**

 \* Physician signature required for all levels except 7 & 7a \*

**-4-**



**SY 2023-2024 Nutrition Order**

**Form D**

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

**Liquid Thickness Modification**

**\*Physician Signature Required\***

(i.e., liquid intake, liquid thickness)

**Liquid Thickness IDDSI Levels (check one):**

[ ]  **Level 3: Moderately Thick/Liquidised:** can be eaten from spoon or drunk from cup; requires wide straw.

[ ]  **Level 2: Mildly Thick:** liquids are sippable but require effort to flow through standard straw.

[ ]  **Level 1: Slightly Thick:** liquids are thicker than water; can flow through a straw.

**If you checked Level 1,2 or 3, you must complete Form E for Supervision and Safety Modifications for Mealtime**

**Physician Signature: Date:**

**Physician Print Name: Date:**

[ ]  **Level 0: Thin:** liquids flow like water. *(no physician signature required for this level ONLY)*

**Parent/Guardian Signature:**  **Date:**

**Parent/Guardian Print Name:**

**-5-**



**SY 2023-2024 Nutrition Order**

**Form E**

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

**Safety Modifications/Considerations for Mealtimes**

**Restrictions or Special Instructions/Considerations:**

Do you do anything special to set your student up for success or safety at mealtime? (i.e. portioning/rationing throughout the meal, cutting food into smaller bites/sizes, giving one sip at a time, etc.) Please explain.

**Food Textures -**

**Liquid Textures -**

**Supervision Considerations:**

Does your student require special attention during mealtimes for safety? This could include things like support for self-feeding, stuffing, eating too fast/slow, etc. Please explain.

**Parent/Guardian Signature: Date:**

**Parent/Guardian Print Name:**

**-6-**



**SY 2023-2024 Nutrition Order**

**Form F**

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

**Gastrostomy Tube Feeding Order Form for School Feedings**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_

Gastrostomy Tube Size: \_\_\_\_\_\_\_\_FR \_\_\_\_\_\_\_\_cm

If GJ Tube is present, please check here: \_\_\_\_\_ Size: \_\_\_\_\_\_  Button/Long (circle one)

Formula Name:

|  |  |  |  |
| --- | --- | --- | --- |
| **Times** | **Formula Amount** | **Water Amount** | **Rate** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Nothing By Mouth (NPO):  Yes   No  *(If no, please fill out Forms C, D, and E as needed)*

Feeding Method: \_\_\_\_\_ Bolus

 \_\_\_\_\_ Gravity Drip/Feeding Bag

 \_\_\_\_\_ Feeding Pump (type of pump\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 \_\_\_\_\_ Bolus-push feeding

Feeding Position: \_\_\_\_\_ Sitting

 \_\_\_\_\_ Supine with head elevated

 \_\_\_\_\_ Side-lying on the right with head elevated

 \_\_\_\_\_ Side-lying on the left with head elevated

 \_\_\_\_\_ Prone on wedge with head elevated and to one side

 \_\_\_\_\_ In a prone stander

Physician PRINTED First and Last Name Physician Signature

Physician Address Date

Physician Phone Number Physician Fax Number

**-7-**



**SY 2023-2024 Nutrition Order**

**Form G**

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

**Selective Eater Information**

(Does your student have eating habits that include limited food preferences or

extreme pickiness that we should know about?)

What foods does your student regularly accept at home?

Has your student attended a specialty feeding clinic (i.e. Mt. Washington, KKI, etc.)?

[ ]  YES- please send in any information that may be helpful in setting your student up for success while eating at school- discharge paperwork, reports, plans/protocols, etc.

[ ]  NO

Are you interested in consulting with MSB’s Nutritionist about your student’s diet?

[ ]  YES- please sign the Specialty Clinic Permission Form (separate)

[ ]  NO

**Parent/Guardian Signature: Date:**

**Parent/Guardian Print Name:**

*\*A member of your student’s IEP team will be in contact with you if/when additional information is required, or if requested, your student is scheduled for Nutrition Clinic\**

**PB/SF/cic:5/2/23**

**-8-**