



**SY 2026-2027 Nutrition Order**

**Student's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Please answer ALL 6 of the following questions and sign at the bottom.

<i>Additional forms are required and noted for some students- please follow instructions noted in each 'yes' or 'no' box.</i>		
<b>1. Food Allergy- specific foods to avoid</b>	<b>NO</b> <i>(Fill out Form A- check No Known Food Allergies box- top section)</i>	<b>YES</b> <i>(Fill out Form A)</i> <b><u>Physician Signature Required</u></b>
<b>2. Special Diet Need- does your student require modification to the school menu?</b>	<b>NO</b> <i>(No additional forms required)</i>	<b>YES</b> <i>(Fill out Form A)</i> <b><u>Physician Signature may be Required</u></b>
<b>3. Food Texture Modification (IDDSI)</b>  *if level has changed, SLP/Physician documentation may be necessary	<b>NPO - nothing by mouth</b>  <i>(Fill out Form E)</i>	<b>NO</b>  <i>(Fill out Form B)</i>
<b>4. Liquid Thickness Modification (IDDSI)</b>  *if level has changed, SLP/Physician documentation may be necessary	<b>NPO- nothing by mouth</b>  <i>(Fill out Form E)</i>	<b>NO</b>  <i>(Fill out Form C)</i>
<b>5. Supervision/Safety Modifications for Mealtime (e.g., meal prep to cut food, monitor rate of intake, etc.)</b>	<b>NO</b> <i>(No additional forms required)</i>	<b>YES</b> <i>(Fill out Form D)</i>
<b>6. Gastrostomy Tube (G-tube) Feeding Order</b>	<b>NO</b> <i>(No additional forms required)</i>	<b>YES</b> <i>(Fill out Form E)</i> <b><u>Physician Signature Required</u></b>

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Print Name:** \_\_\_\_\_



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**Form A** Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**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 Diet Restrictions**

Requirement: \_\_\_\_\_

**Lifestyle Diet Restrictions**

Requirement: \_\_\_\_\_

**NO KNOWN FOOD ALLERGIES**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Print Name: \_\_\_\_\_

**Nutritional/Medical**

Please detail specific requirements (use Form E for g-tube): \_\_\_\_\_

\_\_\_\_\_

**Dairy Free**

**Lactose Free- any exceptions? (i.e. certain cheeses)** \_\_\_\_\_

**Food Allergy**

Food: \_\_\_\_\_

Reaction: \_\_\_\_\_

Severity- Anaphylaxis? YES NO

**Selective Eater**

Explain: \_\_\_\_\_

\_\_\_\_\_

\*Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Physician Print Name: \_\_\_\_\_



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**Form B** Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**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 Fezell, Supervisor of Speech & Language Services ([saraf@mdschblind.org](mailto:saraf@mdschblind.org); 410-444-5000 x1337).

**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 with a spoon; does not require chewing; smooth, not sticky; cannot be drunk from a cup or sucked through straw.
- **If you checked Level 4, 5, or 6, you must complete Form D for Supervision and Safety Modifications for Mealtime**
  - **\*\*\*If level has changed since last year, documentation may be necessary- please email [saraf@mdschblind.org](mailto:saraf@mdschblind.org) before turning in your packet**

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Print Name:** \_\_\_\_\_

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



**SY 2026-2027 Nutrition Order**

**Form C** Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Liquid Thickness Modification**  
**\*Physician Signature Required\***  
(i.e., liquid intake, liquid thickness)

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

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

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Print Name:** \_\_\_\_\_

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- Level 1: Slightly Thick:** liquids are thicker than water; can flow through a standard straw.
- Level 2: Mildly Thick:** liquids are sippable but require effort to flow through a standard straw.
- Level 3: Moderately Thick/Liquidised:** can be eaten from spoon or drunk from cup; requires wide straw.

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

- **\*\*\*If level has changed since last year, documentation may be necessary- please email [saraf@mdschblind.org](mailto:saraf@mdschblind.org) before turning in your packet**

**\*Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*Physician Print Name:** \_\_\_\_\_

\* Physician signature required for all levels except 0



**SY 2026-2027 Nutrition Order**

**Form D** Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**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/Portion/Modification -** \_\_\_\_\_

\_\_\_\_\_

**Liquid Textures/Portion/Modification -** \_\_\_\_\_

\_\_\_\_\_

**Supervision Considerations:**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Print Name:** \_\_\_\_\_



**SY 2026-2027 Nutrition Order**

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

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date this form is being completed: \_\_\_\_\_

Gastrostomy Tube Size: \_\_\_\_\_ FR \_\_\_\_\_ cm

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

Formula Name: \_\_\_\_\_ Which port for formula G or J (Circle one)

Blenderized (prepared at home): YES NO

Times	Formula Amount	Water Amount	Rate

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

Feeding Method: \_\_\_\_\_ Bolus  
 \_\_\_\_\_ Gravity Drip/Feeding Bag  
 \_\_\_\_\_ Feeding Pump (type of pump \_\_\_\_\_)  
 \_\_\_\_\_ Bolus-push feeding

Water Flush Method: \_\_\_\_\_ Bolus  
 \_\_\_\_\_ Feeding Pump  
 \_\_\_\_\_ Push  
 \_\_\_\_\_ Mix with Formula

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