DeKalb County
School District

DEPARTMENT OF SPECIAL EDUCATION
5839 Memorial Drive
Stone Mountain, Georgia 30083
(678) 874-7002
Fax (678) 874-7010

PHYSICIAN AND PARENT AUTHORIZATION FOR ORAL FEEDINGS AND/OR TUBE FEEDINGS

School Year 20____ to 20____

STUDENT'S NAME: _____ DATE: _____

DATE OF BIRTH: _____ SCHOOL: **Margaret Harris Comprehensive**

DIAGNOSIS: _____

Please complete the following questions so we may serve the student safely and appropriately.

I. Physician recommended diet:

____Nothing by mouth (NPO)

____ By mouth (PO) Type diet:

- _____ Regular
- _____Chopped
- _____ Puree-indicate texture below
  - ____Baby Cereal
  - ____Mashed Table Foods
  - ____ Regular Table Foods

Liquids:

Regular_____

Thickened _____ If thickened, what consistency?

Nectar _____ Honey_____ Pudding _____

- ____ Stage 1 Baby Foods (smooth)
- ____Stage 2 Baby Food (semi-chunky)
- ____ Stage 3 Baby Foods (chunky)

_____ Supplement to school meal
_____ Solids only by mouth
_____ Liquids by G-tube
_____ Tube Fed G-Tube or J-Tube **(Please circle one)**

Name of Formula _____
Amount at each feeding _____
Times to be fed _____
Amount of water _____
Amount of water to flush _____

II. Type of Feeding:

_____ Bolus
_____ Slow Drip
_____ Pump If pump, what setting _____

III. Swallow study done? Yes No (Circle One) If yes, please attach if available

IV. Contraindications/Precautions and/or Food Allergies: _____

_____

_____ _____
Physician's Signature Date

_____ _____
Parent/Guardian Signature Date