District/School Name ____

FEEDING/SWALLOWING PLAN

Name __________________________ Student ID ____________________

DOB _______ Age _____ Grade _____ Teacher ____________________

Parent(s) ____

Phone (Home) ____________ (Work) ___________ (Cell) ______________

School Case Manager: Name _____________________________________

Location(s)/schedule ____

Phone(s) ____

Primary Physician ______________________________ Phone __________

Other Emergency Contacts: (name, relationship to child, phone) ______________________________
____
____

Emergency Hospital Preference (name, address, phone) ____________________________________
____

Medication effects that need to be considered ____
____

Medical Equipment in use that needs to be considered _____________________________________
____

Precautions/Emergency Procedures related to feeding/swallowing ___________________________
____
____

District/School Name____

FEEDING/SWALLOWING PLAN

Name ___________________________ **Student ID** ______________________

DIET:

Recommended by ____
(attach physician's or medical dysphagia team's orders)

________ full tube feeding (____G tube _____ J tube)
________ full oral feeding
________ mixed oral/tube feeding (describe ______________________________
____
________ parent/guardian provides meals/snacks
________ regular school meals/snacks
________ modified school meals/snacks (Medical Statement for Children with Disabilities Requiring Special Meals in Child Nutrition Programs)
Food/liquid content/quantity ____
____
Food/liquid texture (clarify terminology used and preparation method) __________________________
____
____
Feeding schedule ____
____

SPECIAL EQUIPMENT:

For food preparation ____
For feeding ____
For oral hygiene ____

Comments:

SEATING

_____ regular seating
_____ wheelchair _____ at table _____ tray attached
_____ special seating (describe ____

Comments:

District/School Name____

FEEDING/SWALLOWING PLAN

Name __________________________________ **Student ID** ____________________

POSITIONING:

_____ independently upright
_____ supported upright (how? ____
_____ independently reclining (how? _____________________________angle ________)
_____ supported reclining (how? ______________________________angle___________)
_____ side lying (specify side _____________)
_____ prone
_____ supine
_____ other (describe ____

Comments:

FOOD PRESENTATION

____ bottle ____ cup ____ straw ____ spoon ____ fork ____ knife ____ bowl ____ plate

Volume of food/liquid per presentation ____
If child is fed, name and title of feeder(s) ______________________________________
____
Placement of feeder/assistor (location and proximity to child _________________________
____
Placement of feeding implements ____
Degree of pressure to be applied to feeding implements _____________________________

Comments:

FEEDING PATTERN

Number of swallows per bolus ________
Provide ____ (quantity,type) liquid after ________ (number) of food presentations.

Comments:

District/School Name____

FEEDING/SWALLOWING PLAN

Name ____________________________________ **Student ID** ______________________

SPECIAL TECHNIQUES

_____ sensory stimulation (describe type, timing) ___________________________________

____

_____ volitional cough

_____ volitional throat clearing

_____ head tilting at _____ angle _____ to left _____ to right

_____ head turning to _____ left _____ right

_____ chin lift

_____ chin tuck

_____ holding breath during swallow

_____ supraglottic swallow

_____ super-supraglottic swallow

_____ Mendelsohn maneuver

_____ effortful swallow

_____ other (describe) ____

Comments:

ORAL HYGIENE

_____ Independently clears food from mouth

_____ Requires assistance Who will do this and how? ________________________________

____

_____ Exhibits sensorimotor issues Who will address and how? __________________________

____

____

_____ Independently brushes teeth/rinses mouth

_____ Requires assistance by ____

Tooth brushing schedule ____

______ Has oral prosthesis Cleaning schedule_______________________________________

Comments

District/School Name____

FEEDING/SWALLOWING PLAN

Name __________________________________ **Student ID** ____________________

CHILD'S GOALS AND OBJECTIVES

_____ in IEP
_____ in 504 plan

TRAINING PLAN (School personnel, parents)

FOR	BY	WHAT	WHEN	WHERE	VERIFIED BY

ADDITIONAL COMMENTS