Overbrook School for the Blind
FEEDING FORM

Student Name____

DOB_________________________ **Program**___________________

____**Trained Feeding Partners Only** ***(if checked only those listed on feeding information form may feed the student)***

Please Check One :
Liquid
___NO liquids by mouth
___Regular/thin liquids
___Nectar thick
__Honey Thick
__Therapeutic Trials with SLP (indicate level)__________

Please Check One:
Food
____NO food by mouth
____Level 1 Puree foods
____Level 2 Ground/ mechanically altered (moist, soft textured, no larger than ¼ inch pieces)
_____Level 3 Advanced/Chopped (moist, nearly regular textured bite size pieces)
_____Level 4 Regular/ no modification to food necessary
_____Therapeutic Trials with SLP (indicate level) ______________

____**NPO** (no food, liquid or medication by mouth)

FOOD ALLERGIES/INTOLERANCES_______________________________________
FOLLOW-UP/RECOMMENDATIONS:_______________________________________
Date of last VFSS_________________**Date of last visit to feeding clinic**_______________

I_______________________________________**(parent/guardian) give Overbrook School for the Blind permission to contact my child's doctor regarding speech/feeding/swallow/diet/nutrition concerns**

Name of doctor/practice:____

Address: ____

Phone/Fax:_______________________ __________________________________

Parent signature____**Date**____________________

Physician's Signature_________________________________ **Date**_______________________