

FEEDING STUDENTS IN EDUCATIONAL PROGRAMS



January 2015

Oregon Guidelines and Information on Safe
Mealtime Practices for Special Students

Connie Hector, MEd, Editor

Regional and Statewide Services for Students with Orthopedic
Impairments | Douglas ESD

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GUIDELINES AND INFORMATION ON SAFE MEALTIME PRACTICES FOR SPECIAL STUDENTS

Revised Edition
2015

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This manual represents the collective work of Feeding Specialists throughout the state of Oregon. The Oregon Department of Education (ODE) first published the *Feeding Students in School: Providing Guidelines and Information about Safe Feeding Practices for Special Students* in 1992, followed by the 2nd edition in 2002 with the current title. This revised edition contains updated guidelines, information, forms and protocols provided and reviewed by feeding specialists in the educational settings throughout Oregon. This guide is not meant to replace the expertise and experience of the specialists working in this field, but rather bring together information to help their work in this specialized area of practice.

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FEEDING STUDENTS IN EDUCATIONAL PROGRAMS

OREGON GUIDELINES AND INFORMATION ON SAFE MEALTIME PRACTICES FOR SPECIAL STUDENTS

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INTRODUCTION

The Feeding Manual is designed to provide guidance for Feeding Team Members and Educational Administrators in serving the needs of children who struggle with feeding and swallowing issues in Early Intervention, Early Childhood Special Education and School Programs up to age 21. Children require adequate nutrition for normal growth, cognitive development, strength and stamina. Often feeding issues become apparent when the child is evaluated for Early Intervention services. In this case the Feeding Team works closely with the parent and medical providers to help the child develop the skills necessary to eat safely.

While in the school environment, there are numerous situations where the child may need to eat and drink throughout the day. In addition, satisfying their nutritional needs and eating safely while at school may be an issue for children with disabilities. Many of these students struggle every day to stay engaged in school due to poor nutritional intake or severe feeding and swallowing issues. Statistics through the Oregon Department of Education from 2013, show there are about 700 students with orthopedic impairments, over 8,000 students eligible under the category of autism, over 11,000 students with other health impairments and over 250 students with traumatic brain injuries identified. Students with feeding issues generally fall into one of these categories requiring special education that include services from a multidisciplinary Feeding Team in developing a plan and follow-up needed for safety and nutrition.

The manual contains information and resources compiled to assist Feeding Team Members and Administrators to address these issues in their local districts. As the numbers of students identified with feeding and swallowing issues has increased, the importance of up-to-date guidelines has increased. A multidisciplinary feeding team is necessary to gather information from the parent, medical community and any past educational records to make an informed decision regarding the ability to eat and drink safely at school and establish an individualized protocol. The Team may include occupational therapists (OTs), speech language pathologists (SLPs), nurses (RNs), physical therapists (PTs), and dietitians. As such, these licensed members work within the scope of their professional practice and follow strict guidelines for establishing protocols, training staff and monitoring of students with feeding and swallowing issues.

The Feeding Team Members should maintain contact with the family and medical providers to remain updated on any medical changes that would require an adjustment in the service delivery or protocol for the student. The feeding assessment, intervention, training of school staff, and development of feeding protocols addressed in this manual are meant to provide guidelines regarding these complex issues of feeding and swallowing. Regional and Statewide Services for Students with Orthopedic Impairments and the Oregon Department of Education are committed to providing resources for students served throughout the state by offering continuing education and provision of this manual to serve as a resource in the educational setting.

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Since the day our beautiful journey began with our son, we have needed support with feeding. Our early intervention has been there since day one working on stimulating his muscles to suck and how to swallow a milk bottle. Then, we moved onto solids and that was a much needed time for early intervention! It took a lot of time and exercises to teach him how to eat. Early Intervention understood our concerns and calmed our fears and explained why our son needed some support. We needed different supplies and therapy knowledge that Early Intervention supplied. Today, Preston is now eating cookies on his own. It is through Early Intervention that my husband and I know how to help our son move onto the next stage. We appreciate the assistance, time, and supplies Early Intervention has supplied our family. We fully entrust our early intervention team with working with our son and it has helped in so many ways!

Jennifer – Parent



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FOR SAFE EATING: IMPLICATIONS FOR EDUCATIONAL PROGRAMS IN OREGON

It is important to understand that feeding and swallowing difficulties put the safety of students at risk every time they are fed or given a drink throughout the school day. A multidisciplinary team of knowledgeable professionals should be involved in evaluating and designing mealtime programs which protect the safety of those students. In addition, school staff should be trained and monitored in the implementation of safe feeding protocols and mealtime plans for individual students. Safe feeding is an issue of student safety and as such deserves the careful consideration of everyone from direct service staff to school district administrators.

Who is at risk for unsafe feeding at school? How does school staff know when a student has a feeding problem?

By the time they reach school age, many children with feeding problems will have been identified, and the school notified upon enrollment. In those cases, recommendations will likely have been made and a safe mealtime plan placed in the child's student record. In some cases, however, a problem may exist that has not yet been identified. School administrators and staff need to be aware of **"red flags"** which can be indicators that a child is at risk for unsafe eating at school. Children who have certain cognitive, motor or behavioral delays may "stuff" more food in their mouths than they are capable of swallowing, and have a choking episode at school.

Children who have a history of aspiration pneumonia, or who are frequently absent due to upper respiratory infections, may be at risk for health problems related to eating. When one or more of these risk factors is observed, it is an indication that more information is needed. The next step depends upon school district procedure. A conversation with the child's parent may be the most appropriate starting point. Alternatively, referral to the Student Services Team, permission to talk to the child's doctor, or a consultation with the school nurse may be in order. If further information is necessary, the child may need to be referred for a feeding evaluation by a district Feeding Team.

Feeding Assessment

For a child with suspected feeding difficulties who is on an Individual Educational Plan (IEP) or Individual Family Service Plan (IFSP), a feeding assessment must be conducted in accordance with IDEA rules for evaluation. It may be important for the administrator to be a part of the decision-making process when issues of student safety are involved. Communication is essential to insure that the district does not commit to a course of action without administrative approval.

Feeding Team

Many school districts, Education Service Districts (ESD's) and Regional Programs have developed collaborative feeding teams to insure they are appropriately meeting the needs of their students with special eating difficulties. Feeding teams are typically comprised of speech/language pathologists, nurses, occupational and physical therapists. Registered dietitians may be called upon for their expertise in nutritional requirements of the child. The role of the feeding team is to evaluate children who have eating problems and to develop mealtime plans in collaboration with the child's IEP/IFSP team or 504 team. Feeding teams also work with special education administrators to develop processes and procedures which take into account the district's legal mandates and liability issues.

In some cases, school districts do not directly employ professionals who have the specialized expertise needed to evaluate and develop mealtime plans and safe feeding protocols. In other cases, assessment of specific feeding difficulties may be beyond the scope of practice for licensed staff. In those situations, it is the district's responsibility to work with other agencies to look beyond district resources for the expertise needed to protect the students in their charge.

Goal of the Manual

The primary goal of this manual is to provide districts and feeding team members with guidelines and sample forms for developing safe feeding practices, while providing adequate nutrition to allow the student to benefit from his/her educational program. **Chapter I** is a general introduction to the issue of safe feeding and its implications for educational programs in Oregon. **Chapter II** outlines the considerations involved in identifying, evaluating, and providing safe mealtime plans for students with special feeding needs in educational programs. **Chapter III** is a guide to developing a district process to insure that safe feeding practices are in place. These guidelines are intended to provide a framework for planning and implementing safe mealtime programs for all students. The guidelines are not intended as "recipes" for design of individual feeding protocols. Each individual student brings with her or him unique needs that must be carefully addressed on a case by case basis.

Terminology

For the purpose of this document, we have chosen to use **specific terminology** in our discussion of safe feeding. Individual school programs may decide to use different terms. What is important is that terms are clearly defined so that all parties involved in the discussion of special feeding practices have a mutual understanding of what is meant. The definitions used in this publication can be found in the chart on **page 3**.

Definition of Terms

Aspiration means inhaling food or liquid into the airway or lungs.

Gastrostomy Tube Feeding refers to feeding via a tube which has been surgically placed into the stomach to provide or augment nutrition and hydration when a child cannot receive it orally. It is often referred to as g-tube feeding. There are other forms of tube feeding (e.g. naso-gastric, gastric-jejunal and jejunal tube feeding).

Malnutrition refers to any condition caused by decreased nutritional intake or by an imbalance of nutrients. A person may display symptoms of under-nutrition by becoming extremely thin, losing muscle tissue, and losing resistance to infection and disease. Malnutrition leads to reduced physical and mental development during childhood and damage may be permanent.

Safe Feeding/Eating Protocol is an individually-designed feeding plan developed by a qualified specialist or a team of specialists for a child with feeding difficulties. The protocol is designed to minimize the effects of a student's oral-motor disability on the activity of eating while at school. A safe feeding protocol is needed for any student at risk for aspiration or choking.

Remedial feeding is a program designed and monitored by a qualified specialist or team of specialists with the intention of helping the student acquire new eating skills. Remedial feeding uses specific therapeutic techniques to facilitate the development of oral-motor movement or to inhibit abnormal oral-motor reflexes. Remedial feeding is a part of a student's specialized instruction and as such includes student goals and objectives as part of the IEP/IFSP. The decision to include remedial feeding must be based on the child's unique needs. The program is developed by the child's IEP/IFSP team through the IEP/IFSP process which includes input from the parent. A remedial feeding program is designed for a specific student when his/her eating ability is judged to impede educational progress and to have potential for change. A student may also have goals and objectives about nontherapeutic feeding issues, such as gaining independence in the lunch room, making correct food choices or requesting assistance appropriately.

Safe Eating or **Safe Feeding** apply to all instances of eating in educational programs. Safe feeding/eating is protection from a life threatening episode of choking or aspiration brought on by poor feeding or eating techniques, distractions, fluctuating health conditions or lack of staff knowledge and training. All of these mealtime programs require specific expertise to develop and implement. The term, "eating" is used to specify self-feeding or eating in general, while "feeding" takes two people: a trained adult feeder, and a child who participates to be fed.

Specialist is used here to mean a nurse, occupational therapist, speech/language pathologist or registered dietician, because they traditionally have specific instruction in the area of feeding disorders as part of their basic training. In addition, many physical therapists have taken additional training in feeding disorders and may be considered specialists in this area of practice.

Videofluoroscopy refers to a videotaped x-ray of a person swallowing. Also known as a "swallow study" or modified barium swallow, it provides information about how safely and effectively the individual is able to swallow foods and liquids of varying amounts, textures and temperatures.

RESPONSIBILITIES OF THE SCHOOL DISTRICT

It is the duty of the school district to provide for the safety of all students in the educational program. For children with complex medical needs, schools and EI/ECSE programs increasingly face new challenges. Medical technology has advanced rapidly in recent years. Children survive a variety of serious medical conditions such as extreme prematurity, cardiac disease, chronic lung disease, as well as a variety of gastrointestinal tract disorders. Often, following resolution of the primary underlying medical condition, the infant/child is left with a secondary oral feeding disorder. Examples are a neuromuscular or structural problem, gastro-esophageal reflux, an aversion to certain tastes, smells, or textures, or an inability to gain weight. The educational program is responsible for planning and implementing an individualized feeding program that safely meets the health and nutritional needs of the student who has feeding difficulties.

There is established legal precedent for provision of special health-related support services, such as special feeding interventions, in educational programs. In March of 1999, the US Supreme Court ruled in a case from the Eighth Circuit regarding school health services, that when such services are needed in order for a child to attend school, they are required as related services under IDEA. The Oregon Administrative Rules regarding school Health Services (Section 581-022-0705), state that, “(1) The school district shall maintain a prevention oriented health services program for all students which provides, (d) Services for students who are medically fragile or have special health care needs.”

As a “health service”, safe feeding is clearly a related service, and as such is a requirement of FAPE, the “Free Appropriate Public Education” guaranteed under IDEA. Monitoring of individualized mealtime programs can be a complex and time-consuming task. School district administrators and their professional staff must address concerns about feeding in such a way that risk to students can be reduced through attention to increasing the safety factors related to feeding.

Evaluation and management of children with feeding difficulties requires specialized expertise. In some cases, this will be an individually-designed mealtime program.

A mealtime program is:

- Necessary to support a student’s educational performance or to allow a student to access their educational program,
- Recommended by the child’s IEP/IFSP team,
- Developed and monitored by individuals with expertise,
- Listed in the IEP/IFSP as related services, modifications, or supplemental aids and services,
- *May include* goals and objectives specified in the child’s IEP/IFSP.

CONSIDERATIONS FOR IEP/IFSP TEAMS

Risk

Numerous factors must be considered when determining whether a child may be at risk while eating.

Risk factors may include:

- Abnormal muscle tone
- Seizure disorder
- Sensory issues
- Behavioral issues

- Frequent respiratory illnesses
- Inability to ingest adequate nutrients to sustain growth and development
- Other health conditions

A more comprehensive list of potential **Risk Factors** may be found in the **Resources** section. An individual student may exhibit a combination of several of the risk factors listed. The exact combination and severity of each factor can vary from day to day and at different times of the day. Other factors may also influence the student, such as fatigue, illness, medications, inadequate caloric or nutrient intake, and a loud, distracting environment, etc. Under the direction of a specialist, the use of a **Safe Feeding Checklist** (see the example in the section entitled **Sample Forms and Protocols**) will assist caregivers in determining the safest course of action in feeding the student with a feeding disorder at a particular meal.

Feeding another person is a risky business. Students with oral sensory or musculature difficulties, are at risk for a life threatening incident every time they eat or are fed. Children may inhale food during feeding without showing any sign of distress. Food may build up in the mouth or pocket of the throat unbeknownst to the feeder until it dislodges and chokes the child. A child may have a seizure when food is present which can block the airway. It is important that school personnel and staff recognize the critical nature of the eating process and attend carefully to these guidelines.

Delegation of Tasks

According to law, some activities are considered nursing tasks which can only be undertaken by a nurse or by someone whom the nurse has delegated, or authorized, to do the task. Delegation involves training by the nurse in how to perform the task, and ongoing monitoring to insure competence.

Gastrostomy tube feeding is one of these **delegable nursing tasks**. There are some students enrolled in school who, regardless of the expertise of those doing the feeding, cannot be safely fed by mouth. Gastrostomy tube feeding can safely occur in school with training and delegation by a registered nurse.

Other specialists, including occupational therapists, speech pathologists and physical therapists hold professional state licensure that qualifies them to perform specific evaluations and establish programs based on the evaluation findings. The program set up by the licensed professional must be followed by educational staff to ensure student safety.

District Liability

The Oregon Administrative Rules, Section 581-022-1420, states, "The school district shall maintain a comprehensive safety program for all employees and students which shall: (1) Include plans for responding to emergency situations." To insure that a district has provided students with safe feeding practice, the following activities need to be undertaken:

1. Determine the care to be given to the student and document it in the student's Health Care Plan and/or IEP/IFSP.
2. Develop prescriptive and therapeutic measures that are correctly planned, executed and monitored by the appropriate personnel.
3. Make notation of student behaviors relative to feeding and specific responses to feeding events.
4. Maintain current, signed documentation which is recorded by appropriate personnel.
5. Maintain a log of monitoring and training activities carried out by the responsible specialist.

Students at Risk

One of the most difficult situations arises when a family feels their child can safely be fed orally, but the educational team disagrees. Generally, when it is determined that a student is at risk for choking/aspiration from oral feeding, the family and the child's physician may decide to place a feeding tube. However, in some instances, a family will decide against this surgery and request that the school district provide oral feeding. This is the **highest risk feeding situation** that a school district can encounter. Medically-trained professionals must follow their professional judgment when they determine that it is unsafe to feed a child at school. In this instance, the district may ask the parent to feed the student at home. In all cases, feeding decisions need to be made by the IEP/IFSP team in collaboration with the feeding team and the administrator, following appropriate procedural safeguards. If a modified school day is being considered, a revision of the IEP/IFSP is necessary because this is a placement decision.

Important Note: Having a family member feed a child at school who is otherwise considered to be at risk if fed orally does not relieve the school of legal liability for the child's safety at school.

Professional Liability and Scope of Practice

Licensed personnel including nurses, occupational therapists, physical therapists and speech/language pathologists are **required** by their licensing laws to perform their duties in such a way they do not violate the law. It is important for specialists practicing in educational programs to know local school and district policies, as well as their scope of practice, code of ethics and state licensing laws for their profession. Behaviors which are considered to be negligent and which may elicit charges of malpractice include:

- Failure to follow physician's written precautions;
- Failure to follow standard procedures for their profession;
- Failure to recognize a student's needs and follow up with appropriate intervention
- Timely re-evaluations;
- Failure to follow guidelines for delegation under licensing laws.

Contact information for various Oregon state professional licensing boards is listed as **Resources in Oregon** in the **Resources** section.

Resources

Providing a quality feeding program requires the expenditure of resources. Cost depends on a number of factors. **Extensive evaluation, program development, training and monitoring** may be needed to assure that students with oral-motor difficulties are safely fed. The following resources may be required:

Staff Time: Included in the process of developing a plan will be the need for team meetings to develop team consensus and follow through.

Evaluation by an outside agency: It may be necessary to obtain an outside feeding evaluation that involves evaluation of a student's swallowing pattern. When an outside evaluation is recommended by school personnel, the school may be required to pay for the evaluation. Since these are medical evaluations, family medical insurance, or third-

party reimbursement through Medicaid (not to be confused with the Education-Based Medicaid program) may cover part or all of the costs. Pre-authorization of payment should be explored prior to initiating the evaluation. However, parents cannot be required to use their private insurance coverage. They may do so on a voluntary basis only. Requiring parents to use private insurance would violate the child's right to FAPE (free appropriate public education).

Staff Training: It may also be necessary for a district to incur the cost of staff training by an outside agency. Training educational staff to feed specific children can be carried out by qualified district personnel, such as an occupational therapist, a physical therapist, speech/language pathologist or nurse. However, OT's, PT's, SLP's, and even school nurses may need additional training specific to complex feeding needs. In addition, the time taken by personnel for evaluation, planning, training and monitoring of direct care staff can be extensive, as training must be done on a **one-to-one basis** and each student must have more than one person trained to meet his needs. It is strongly recommended that all persons feeding students with eating disorders have current training in CPR and abdominal thrusts. Modified techniques for the specific individual being fed may be necessary. This training may involve a cost to the district.

Equipment: The purchase of specialized equipment is another cost factor. The equipment needed to feed students may include special cups, glasses, bowls, utensils, bolsters and other positioning devices, as well as appliances such as a microwave, refrigerator and blender.

ROLE OF THE FEEDING TEAM

A team and/or a case manager should be designated for each student who has feeding problems to insure that proper procedures have been completed prior to the initiation of a feeding program. Many school districts and ESD's have chosen to develop multidisciplinary teams of professionals who have expertise in the area of feeding.

The feeding team is responsible to:

- Evaluate children referred for feeding difficulties,
- Refer to outside agencies, if needed,
- Develop recommendations, mealtime plans or feeding protocols
- Train staff to implement feeding recommendations
- Provide ongoing monitoring and evaluation.

Administrative support is critical to the work of the feeding team in the development of guidelines, policies, procedures and processes. Chapter 3 of this manual details the considerations involved in developing a district process for evaluation and intervention by the feeding team.

Members of the feeding team require advanced and ongoing training to increase their skills and knowledge in the field of feeding and swallowing disorders. If expertise is not available from the local school district staff, the district should seek it from an outside source. For example, while school nurses provide comprehensive health services to the general school population, they may not have experience with feeding issues. School nurses specializing in students with complex health needs have expertise in

working with children who have disorders that impact their ability to eat safely. Such expert knowledge may not be available in all districts. When it is not, administrators must assist their staff to gain the knowledge and expertise necessary to assure student safety either through training or through consultation with other districts or agencies.

Composition of the feeding team will vary from one school district to another but may include the following disciplines:

- Occupational therapist
- Speech/language pathologist
- Nurse
- Physical therapist
- Registered Dietician
- Teacher
- Parent (for child in Early Intervention)

The parent will know their child best and may have updated medical information regarding any feeding issues that may be encountered at school. Parents are an important member of the team. While feeding difficulties are typically identified early in the child's life, these issues change over time and need frequent monitoring to keep students safe in the school environment. The feeding team must be experienced in working with children who have orthopedic, neuromuscular or other disorders that may impact the student's ability to be fed safely. Refer to page 28 for a listing of possible feeding team members and their roles.

2

EVALUATION & TREATMENT OF FEEDING DISORDERS IN EDUCATIONAL PROGRAMS

REFERRAL

Children may be referred for an evaluation of their feeding in several ways:

- A child who has been previously identified may transfer from another program
- A parent may request assistance or information about their child's feeding
- The IEP/IFSP team may note risk factors such as those listed in the **Resource** section.

Effective management of a feeding disorder begins with a thorough assessment of the eating/feeding process and its component problems. While feeding an infant or child with normal capability is generally considered a simple task, feeding a child with a neuromuscular disorder is much more complex. The child may have:

- Poor oral motor skills
- difficulty keeping liquids or thin pureed foods in their mouth
- decreased ability to suck, swallow or chew
- delayed swallowing due to seizures, decreased alertness or processing time
- history of choking or aspiration

For these reasons, it is critical that a child with feeding difficulties be fed only by individuals who are appropriately trained and monitored by licensed specialists with specific expertise in feeding.

To insure safe feeding, an evaluation of the student's positioning needs, oral motor skills, calorie and nutrient requirements and food texture (tolerance/needs), medications, general health, and possible allergies, must be completed prior to development of the feeding protocol or mealtime plan, and performance of feeding at school. Chapter III describes in detail the steps which should make up the process, from evaluation through training and implementation of an individualized mealtime program. It also covers the procedural safeguards which must be observed in conducting any evaluation for a child on an IEP/IFSP.

PROCESS

At the outset of the feeding evaluation, it is essential that key information be gathered about the student. This should include a thorough **Nursing Assessment**, using a format such as the one provided in the **Sample Forms and Protocols** section, which gives a detailed history obtained from the parent or caregiver. Medical records pertinent to feeding should be requested and information included in the

history. It may be necessary to consult the student's physician if medical questions remain after obtaining the history. The team should also review educational records, including the IEP/IFSP.

Following the history, the team conducts the actual assessment of the child's eating/feeding skills. It may require more than one observation session to evaluate the child's eating and behavioral patterns. It is considered best practice to have the parent present during the feeding evaluation to demonstrate how the child is fed at home. Similarly, school staff should be observed feeding the child as they typically do.

Once the assessment is completed, the team will develop a safe mealtime plan for the child. The plan, which must be in writing, should address:

- Positioning
- Specialized equipment
- Food textures
- Oral care
- Food likes/dislikes
- Allergies
- Feeding procedures
- Techniques for communicating
- Precautions and emergency protocols
- Guidelines for medication administration
- Documentation of training with signature page for staff members trained

DETERMINING THE NEED FOR A MEDICAL FEEDING EVALUATION

If the educational feeding team suspects that a student may be at high risk for choking and/or aspiration if fed orally, a referral from the child's physician may be necessary to obtain a feeding evaluation from a medical feeding disorders clinic. Some medical feeding clinics in Oregon are found at the Child Development Rehabilitation Centers at both Doernbecher Children's Hospital, Portland and in at the Clinical Services Building in Eugene, Providence Neurodevelopmental Centers for Children, Salem Regional Rehabilitation Center; Rogue Regional Valley Medical Center, Children's Developmental Health Institute at the Artz Center, and Legacy Emanuel Children's Hospital.

Effective management of a feeding disorder may require a thorough medical assessment of the major components that influence the feeding process. Medical team members may include a pediatric gastroenterologist, developmental pediatrician, a diagnostic radiologist, a speech/language pathologist, an occupational therapist, a physical therapist, a nurse and a registered dietician.

When the school district refers a child for a medical evaluation, it is important they communicate to the child's family and physician their reasons for the referral. Based upon the information provided by the team and family, the child's physician determines whether or not to refer the child on for the requested evaluation. It is imperative that the team communicates as clearly as possible their specific concerns about the child's eating. Most often, the child's primary physician has not had an opportunity to observe the child during mealtime. The observations of the feeding team provide valuable information to the child's physician and the medical team.

A comprehensive evaluation completed by a multidisciplinary medical team will encompass any medical diagnostic procedures needed to determine the child's health and physical status. It will also include assessments of normal and abnormal movement and postural components relative to feeding, nutrition, oral-motor performance, swallowing, and finally, the psychosocial and behavioral influences of the feeding disorder on the child and the family.

Videofluoroscopy or Modified Barium Swallow

If a swallowing disorder is suspected, referral for a modified barium swallow may be ordered by the physician for the child's health and safety. A modified barium swallow is a medical evaluation which must be done in a facility where there is x-ray equipment and pediatric specialists to perform the test and analyze the results. The specialists may include the radiology technician, radiologist, speech pathologist, and occupational therapist. An x-ray of the child is taken while the child is eating a variety of liquids and textures. This test gives a picture of whether a child is aspirating (inhaling) food or liquid into the airway and/or lungs or is at risk for aspiration. The swallow study will show which parts of the mouth and throat are working normally, where there is dysfunction and what kinds of food are safe to swallow. If the child has difficulty sitting up, there may be adapted seating and positioning required to complete the swallow study or the parent may be asked to support their child during the test while wearing a protective cover up.

The videofluoroscopy helps the medical team provide information and recommendations to the family, the physician and the education-based feeding team regarding positioning for feeding, food types, textures, temperatures and amounts that the child can safely manage. The test may indicate the student is not safe for oral feeding or drinking. While the videofluoroscopy may be costly, it is essential in the management of children who have a swallowing disorder. The videofluoroscopy study is an essential piece of the feeding and swallowing assessment.

Gastroesophageal Reflux (GER) and Gastroesophageal Reflux Disease (GERD)

If the child is experiencing Gastroesophageal Reflux, where the contents of the stomach flow backward into the esophagus, medical diagnosis and management are critical. For safety reasons, whether a child has GERD is an important piece of information for the feeding team during assessment and/or treatment. When aspiration and/or reflux occur, the child is at high risk for severe respiratory difficulties, inflammation of the esophagus (esophagitis) or infection. Pain from esophagitis may cause arching of the back, sweating or a food aversion. Signs of aspiration secondary to esophagitis may include:

- Choking
- Wheezing, stridor
- Chronic cough
- Gagging
- Congestion
- Hoarseness or sore throat
- Abdominal or chest pain
- Posturing with opisthotonus or torticollis (Sandifer syndrome)
- Recurrent pneumonitis
- Dysphagia
- Sour smelling breath or sour mouth odor

If GERD is suspected by the feeding team, this information should be shared with the parent and medical provider.

Conservative treatment of GER may include:

- Frequent, small thickened cereal
- Upright positioning after feeding for 30 to 60 minutes
- Elevation of the head if in bed
- Prone positioning (infants > 6 months)

Esophageal pH monitoring has demonstrated significantly less GER with prone positioning in infants. While this may be helpful for infants where complications of GER **outweigh** the potential increased risk of Sudden Infant Death Syndrome (SIDS). Prone sleeping is not recommended due to the possibility of SIDS associated with infants sleeping in the prone position. Members of the infant feeding team may want to discuss this issue with the medical provider for guidance or recommendations.

As children get older, dietary recommendations may include avoiding foods with tomato and citrus products, chocolate, fruit juices, peppermint, caffeinated beverages and lower fat diets (lipids slow gastric emptying). Families will work with their medical professionals to help guide them in the treatment of these problems which may include the use of medications. If the GER is not well controlled, a surgical procedure called a **fundoplication** may be required when other treatment has failed. The fundoplication tightens the lower esophageal junction, preventing stomach acid or stomach contents from ascending and causing pain, discomfort or damage to the esophagus or airway.

Determining the Need for a Nutritional Screening and Assessment

Children with feeding disorders are at high risk for malnutrition because of poor nutrient intake and poor utilization of nutrients. Children with nutritional disorders may be small for their age, thin, and may present with limited alertness. Poor nutrition is associated with:

- Compromised immune system
- Decreased bone growth
- Short stature
- Diminished physical activity
- Long term impairment in cognitive development
- Lowered academic performance and socio-affective competence

Malnutrition may impact cognition in the following ways:

- Learning disabilities
- Decreased IQ scores
- Decreased language development
- Memory deficiencies
- Reduced social skills
- Reduced problem-solving abilities
- Attention deficit disorder

Nutritional problems usually arise secondary to other physiologic and psychosocial problems and may

not be resolved permanently without addressing the underlying conditions that affect the child. Nutritional problems may be prevented through early identification of children at risk, nutritional assessment, intervention and monitoring the success of the intervention. Assessment of children at risk for nutritional disorders should include the following:

- nutrition screening
- nutrition assessment
- health and feeding history
- dietary assessment
- growth profile
- physical examination
- feeding assessment

Nutrition Screening “A Look at Diet and Health” (see *Sample Forms and Protocols*) identifies nutrition concerns for the child. The purpose of the nutrition screening is to identify children who appear to have nutrition problems that require further investigation or who are at-risk for developing a nutrition problem. Anyone working to assure the health of infants or children with special needs may use the Nutrition Screening form. The completed Nutrition Screening form should be reviewed and scored by a care coordinator or other health professional to determine the level of nutrition risk. The total nutrition screen score provides a quick and easy way to determine what action to take. Anticipatory guidance and information may be provided to families of children with low levels of nutrition risk, potentially preventing the need for further nutrition services. For those children with a high level of nutrition risk, the children may need to be referred for other services for a more in-depth nutrition or medical assessment.

A more in-depth guide to using the Nutrition Screening form may be obtained by contacting the Registered Dietician or Feeding Team at CDRC. Contact information is included in the **Resources** section.

FEEDING INTERVENTION AND TREATMENT

When the feeding team evaluation is completed, a mealtime plan is developed for the child. Depending upon the findings of the evaluation, the plan may include a safe feeding protocol, goals and objectives for the child’s IEP, precautions to be observed or a combination of these.

A **Safe Feeding Protocol** is a program developed by a qualified specialist or a team of specialists to minimize the effects of a student’s oral-motor disability on eating while at school. A safe feeding program is needed for any student at risk for aspiration/choking. It includes safe feeding procedures that are utilized to assure that the student is not exposed to an undue risk of choking and/or aspiration. It insures that the student is adequately hydrated and nourished during school hours. All safe feeding practices outlined in the child’s feeding protocol must be observed. Safe feeding is required under IDEA as a related service because it is necessary in order for the student to benefit from special education (34 CFR 300.24). Accommodations, modifications and supports to staff with regard to feeding should be listed as such on the IEP/IFSP in the appropriate sections. (Example: “Feeding team to provide written feeding protocol, attached.”) If a student requires specific intervention to be fed safely due to an eating disorder, the feeding protocol may be attached to the IEP/IFSP for documentation. In addition to safe feeding practices, a feeding protocol may include remedial feeding goals or objectives related to the

student's acquisition of eating skills. A sample format for developing a feeding protocol and examples of some completed feeding protocols are given in the ***Sample Forms and Protocols*** section. These are examples only, and are not intended for use as individually-designed programs for specific children.

A **Remedial Feeding Program** is a program designed and monitored by a qualified specialist or team of specialists with the intention of helping the student acquire new eating skills. Remedial feeding uses specific therapeutic techniques to facilitate the development of oral-motor movement or to inhibit abnormal oral-motor reflexes. Remedial feeding is a part of a student's specialized instruction and as such includes student goals and objectives as part of the IEP/IFSP. The decision to include remedial feeding must be based on the child's unique needs. The program is developed by the child's IEP/IFSP team through the IEP/IFSP process which includes input from the parent. A remedial feeding program is designed for a specific student when his/her eating ability is judged to impede educational progress and to have potential for change. A student may also have goals and objectives about nontherapeutic feeding issues, such as gaining independence in the lunch room, making correct food choices or requesting assistance appropriately.

Relevance to Safe Feeding in the School Setting

While it is the obligation of a school district to provide safe eating for **all** students, districts are **not** obligated to provide a remedial feeding program for all students who have feeding disorders. **The acquisition of eating skills must be educationally and/or developmentally relevant.** A district is not obligated to provide a remedial feeding program unless the IEP/IFSP team includes goals and objectives on the student's IEP/IFSP that pertain to the acquisition or improvement of eating skills. Feeding goals are more commonly seen on IFSP's.

If it is the decision of the IEP/IFSP team to include remedial feeding/eating in the IEP/IFSP as part of the student's specifically designed instruction, the following criteria should be met:

- The IEP/IFSP should reflect functional eating outcomes as goals
- Objectives must be measurable, with the expected dates of completion designated on the IEP/IFSP
- Remedial feeding/eating should take place as a learning activity, not necessarily during mealtime
- Remedial or safe feeding takes place only when specifically trained personnel are available to feed the student

PRE-FEEDING SKILLS TRAINING

Pre-feeding skills are the prerequisite steps or subskills necessary for eating food orally. Coordination of swallowing and breathing is an important pre-feeding skill, as is the ability to use the tongue to transfer food from the front to the back of the mouth, or the ability to tolerate certain food textures. In some cases, the IEP/IFSP team, in collaboration with the feeding team, may decide that pre-feeding goals are most appropriate for an individual child before remedial feeding instruction can take place. Pre-feeding goals, such as increasing tolerance of various smells, or various textures in or around the outside of the mouth, may include oral-motor stimulation. Such goals should be written in collaboration with the knowledgeable specialist. Work on these goals would be integrated throughout the child's day, during naturally-occurring routines such as face-washing or tooth-brushing, or during appropriate classroom activities such as art, craft or cooking activities, community living skills instruction, vocational skills, etc.

For children whose educational program includes **oral-motor stimulation** activities, it *may* be appropriate to practice chewing under safe, supervised conditions specified by a feeding specialist, such as a snack time.

DEVELOPING A FEEDING PLAN FOR AN INDIVIDUAL CHILD

Certain general considerations should be taken into account when planning to feed students with special feeding needs. All such children have individual issues which are unique to them and their particular environment. In all aspects of feeding, the clinical judgment of the specialist is of paramount importance in ensuring that the child is safe when eating at school. ***General Guidelines for Facilitating Safe Feeding*** have been included in ***Resources***. These guidelines are general in nature, and may not apply to every student.

Student's abilities change as they grow and in some cases due to neuromuscular conditions that are progressive in nature, students may lose the ability to safely eat. A critical part of a student's program is the continued reassessment of function by the specialist to determine if the child's physical and/or cognitive abilities have changed enough to make changes in the feeding plan.

Factors Affecting Safe Feeding



The many factors that can influence the student's response to a feeding program often interact and it can be very difficult to determine the exact cause of an observed problem. Some of these factors are listed below:

Health Factors:

Some students may have health problems that will affect their response to the mealtime program. Factors such as fatigue, medications, allergies, fluctuating tone or alertness can influence feeding safety from day to day or even during the meal, and should be considered on an ongoing basis. A more thorough listing, titled ***Health Factors that Affect Feeding*** can be found in ***Resources***.

Nutrition and Hydration:

Children who have swallowing difficulties are at risk for losing weight, or not maintaining healthy weight gain as they grow. They also risk dehydration on a daily basis for several reasons including:

- Inability to attend to their own needs due to limited movement or cognition
- Aversive to the sensation of liquids
- Safety reasons preventing them from drinking
- Lack of the sensation of thirst

In any of these cases, it may be necessary to offer liquids and foods which are easy for the child to swallow and which boost calorie intake. The ***Resources*** section provides ***Nutritional Ideas*** for simple preparations which facilitate swallowing and promote nutrition and hydration.

The Use of Thickening Agents:

The use of thickening agents for infants and children comes with precautions. When using these products, feeding specialists should check with the medical providers who specialize in feeding and swallowing issues. Currently, the Food and Drug Administration cautions against the use of certain thickening agents for all infants under one year. Caution is recommended when thickening agents are used with children under 12 years old with a history of necrotizing enterocolitis.

Other issues of using commercial thickening agents include getting the same consistency every time and different liquids requiring a different amount of thickener to get the desired consistency. Thickened liquids have also been linked to an increase in urinary tract infections, higher rate of dehydration and pneumonia. Use of thickening agents in the school setting should be discussed with the medical providers and parent for consent prior to use.

Constipation and Proper Elimination:

Although stool frequency is often used to distinguish between normal and abnormal elimination, stool volume and consistency are usually of greater importance. Constipation is a common complaint in children with developmental disabilities due to generalized hypotonia, limited bowel muscle function, inadequate fluid intake, low fiber intake and limited physical activity. Diarrhea refers to an increase in the frequency, fluidity or volume of stool compared to the individual's normal pattern. Either constipation or diarrhea may impact the student's appetite and ability to participate in a feeding program. If there is concern by the school staff, the parent or school nurse should be contacted.

Transition from Tube-Feeding to Oral Feeding:

When it does become appropriate to begin oral feeding at school, it is important that the feeding team and school staff work closely with the family and health care providers. Cooperation between home, school and health care providers assures continuity and safety in the development of a feeding protocol in the school setting. During this transition time, it may not be necessary for the child to eat orally at school if they are receiving adequate nutrition via the gastrostomy tube.

A list of **References** from current literature on feeding children with special needs at school is included in **Resources**. Books on feeding and swallowing are available for loan through the Regional Services for Students with Orthopedic Impairment (RSOI) Statewide Loan Library.

Environmental Factors:

Environmental factors may also impact health and safety when feeding students in school. When considering program location, external stimuli, (e.g., noise, interruptions, interfering activities), may cause a student to react in a way that makes feeding even more unsafe. Frequently, children with feeding disorders may stiffen up in response to external stimulation, preventing safe swallowing from occurring. A quiet location with minimal stimulation is recommended for the student with feeding difficulties. This may mean that a student cannot be fed in the school lunch room or preschool snack environment. If this is the case, it may be possible to feed the student in a quiet place and then bring him to the lunch room for socialization. However, feeding should never occur in isolation. All building personnel should be knowledgeable about how to access emergency assistance. Other environmental factors of concern are a student's right to privacy, food preparation, classroom hygiene and eating utensils.

Mealtime is one of the most important social opportunities for children, and often is one of the times when students with severe disabilities get focused attention. While care to minimize distractions and maintain safety is of utmost importance, maintaining a social/caring environment, taking cues from the child, and asking for their input/allowing choices is also essential. Eating is fun!

1. **Right to Privacy** - Students with feeding difficulties often have trouble closing their lips, therefore they lose food and liquids from their mouths. If the student is sensitive about eating or being fed in the presence of his peers, he should have the option of eating in a private place. Also, if the peers are particularly insensitive about the eating/feeding process, they may need to engage in some class discussion about feelings and teasing. In the meantime, privacy of the student with feeding difficulties may be best protected by being fed in a private area. Socialization, which is often a goal that causes the student to be fed in the school cafeteria, cannot be promoted unless the necessary groundwork is laid.
2. **Food Preparation** - Because students with feeding disorders often have food especially prepared for them in the classroom, care should be taken to insure that food is prepared, handled and served in compliance with current health standards. Cafeteria staff may be willing to prepare and store food, and clean dishes and other equipment. Staff preparing food in the classroom need to be cautious of additional factors affecting the health of the students who are eating foods prepared by them. Microwaving of foods can create hot spots with possible resultant burns to the mouth of a student. Repeated warming and/or lack of refrigeration can cause bacterial contamination of foods. Children who are medically fragile have a decreased immune system and are more at risk of infection due to bacteria introduced from improper handling of food and utensils. Guidelines need to be developed and followed to assure healthful food handling, preparation and storage, use of gloves, adequate refrigeration, and judicious heating of foods.
3. **Classroom Hygiene** - When students eat and are also toileted and/or changed in their classroom, special care needs to be given to insure adequate hygiene. The diaper changing area should be located away from food preparation areas. Handwashing policies need to be developed and monitored for staff and students. Classroom surfaces, (i.e., sink, countertops, bathroom, towel holders, waste receptacles, refrigeration, storage, food containers), should be cleaned and disinfected in compliance with health regulations.
4. **Eating Utensils** - Students with feeding difficulties, whether self-feeding or fed by others, often require special eating utensils. These utensils can help facilitate independence with the self-feeding student or promote ease and safety while feeding a student. Eating utensils may include such things as a cutout drinking cup, plastic coated youth spoon, swivel spoons or a spoon with a built-up handle. Metal and/or flimsy plastic eating utensils are not recommended for use, as they may cause unsafe feeding conditions to arise. The type of utensil used is especially important for the student with a tonic bite reflex as a metal spoon can cause damage to teeth and a flimsy spoon could pose a choking hazard if broken off when eating. Attention to the size of spoon is also important when considering eating utensils and needs to be addressed when training staff.

5. **Food Characteristics** – Children with feeding and or swallowing problems can sometimes eat only certain food textures or temperatures recommended by their physician or knowledgeable specialist. A “Dysphagia Diet” is sometimes prescribed by the physician for a specific patient with a swallowing disorder, or “dysphagia”. These diets are scaled lists which designate food types and textures which may safely be given to a specific patient. Because there are a variety of Dysphagia Diets in use, it is important to know which diet is being referenced when a particular diet level is prescribed. For that reason, it is recommended that school-based practitioners refer to the ***Descriptions of Food Textures***, given in the ***Resources*** section when writing protocols for safe feeding, in conjunction with the recommendations of the child’s physician or medical provider. The definition of food textures may need to be reviewed with staff on a case-by-case basis.

FEEDING IN EARLY INTERVENTION: GENERAL ISSUES

1. Consultation is to the parent, rather than to school staff unless the child is in an educational group setting (such as a toddler group):
 - Opportunity to promote family behaviors that foster the general health and safety of the child.
 - Outcome of the intervention is influenced by parent, who may be unfamiliar with sequence of normal feeding development, and have difficulty understanding that their child's feeding is abnormal.
2. Feeding environment is the home, but may include toddler group setting:
 - Opportunity to enhance the environment to promote safe feeding.
 - Structure of the mealtime environment can impact effectiveness of the intervention.
 - Encourages exploration of food textures in a supported environment.
3. Eating is an emotional issue for families:
 - Feeding is typically a bonding experience between parent and child.
 - Opportunity to influence the emotional dynamic which can develop when the parent experiences difficulties feeding their child or when the child seems not to accept or like what the parent offers them.
4. Eating is a new experience for the young child:
 - For ages 0-3, oral motor structures and surrounding supportive musculature are still developing. The feeding process should be evaluated in the context of other developmental areas:
 - ✓ Are there delays in speech development as well?
 - ✓ Are there sensory issues related to the feeding difficulties?
 - ✓ Are feeding problems related to a developmental behavioral issue?
 - There can be a window of opportunity for intervention in the child's development while they can experience success, and before maladaptive physiological or behavioral patterns can develop.
5. Team Process:
 - While the expertise of a multidisciplinary team is often needed, the impact of multiple professionals entering the home on a regular basis can have a negative impact upon the family. A single contact person is most desirable.
 - It is important to reinforce concepts to parent consistently across team members.
 - Interdependence and communication among team members is critical.

GASTRIC TUBE FEEDING: BOLUS VS. CONTINUOUS GASTRIC FEEDING

Some children with feeding disorders may get some or all of their nutrition by a feeding tube. In a school setting, this task is delegated by a registered nurse who is familiar with the child, has reviewed the child's medical records and has contact with the medical feeding team, such as the developmental pediatrician. The nurse instructs school staff individually to perform this task with the child and must document the training. The two methods of delivering tube feedings is by continuous gastric feeding delivered by a pump over a longer period of time and a bolus feeding which is given through a syringe often using gravity to drain the food into the tube.

There are not many studies regarding the use of continuous vs. bolus feedings for children who are tube fed. Since the school staff is with the child during the day, they understand how well the child does during and after being tube fed. Sometimes a child may not be able to tolerate bolus feeding since more food is given in a shorter period of time. The medical team initially chooses the type of tube feeding depending on history, anatomical placement of the tube taking in account digestive and feeding behavior factors in addition to the expected duration of the tube feeding.

While there has been an increase in the use of tube feeding in children with chronic health conditions, some parents may prefer bolus feeding over continuous drip feeding. While most tube feeding is done with a special formula, some parents or caregivers desire preparing the food for their child who is tube fed. There are many reasons for parents wanting their child to have bolus feeding of homemade prepared foods made with the love of a parent and served during the family meal or as a way to give their child increased variety of foods. It may include the lower cost of the homemade food, concern for the child's weight gain and growth, the ability of the parent to participate in the preparation of their child's food and the dream that the child may someday eat orally.

When a child with a feeding tube come to school, the feeding team develops a feeding protocol based on the medical information, parent reporting and a formal assessment done by the team to make sure the student is safe while at school. Following the evaluation and development of the feeding protocol, training of school staff is done. Below are some differences in the different types of tube feedings:

Continuous Drip Feedings

- Delivered via pump over a period of time or overnight
- May be better tolerated by medically fragile children
- Less reflux, vomiting, dumping syndrome and diarrhea
- Recommended for preterm or term infants with persistent feeding intolerance, respiratory instability or significant gut resection
- Improved absorption of major nutrients in infants with intestinal diseases
- Restricts movement
- More expensive
- Increased caloric intake, particularly with continuous drip feeding at night
- Used with gastric-jejunal or jejunal tubes

Bolus or Intermittent Tube Feedings

- Allows greater mobility
- Feedings can be scheduled
- Used in children more medically stable
- Promotes GI development

In some instances an infant or child may require nasogastric feeding where the feeding tube is placed through the nose. This is usually done for a shorter period of time, generally less than three months, and must be checked for proper placement by a medical specialist to avoid food from going into the lungs if the tube has been pulled out of the stomach or placed improperly.

Some Guidelines for Homemade Blended Formula

Parents may be cleared to use formula that is made at home by the parent for their child who is tube fed. If this is the case, there should be guidance from the medical providers and the nurse on the feeding team to ensure safe feeding in the school environment. Some information for homemade blended formulas include:

- Cannot be left unrefrigerated for more than 2 hours
- Leftover food is stored in glass or plastic container with tight lid and discarded after 24 hours
- More risk of infection due to bacteria in food, thus not always recommended for medically fragile students who have a decreased immune system
- Less expensive for the family
- Increases variety of foods
- Child may show more interest in food
- Child can make choices of foods, thus increasing participation in mealtime
- Parent may feel a more active role in preparing food for child
- Makes mealtime more family oriented and less medical
- May decrease reflux, constipation and diarrhea
- May improve child's weight gain, nutrition and growth

The delivery system of food for a child who is tube fed is primarily a medical decision. If the child at school does not appear to be tolerating the type of tube feeding being provided, the school feeding team or nurse should be contacted in order to work in a collaborative manner with the family and medical specialist to adjust the feeding method for the student.

TRAINING AND MONITORING OF MEALTIME PROGRAMS

Training and monitoring of people who feed children at school is the responsibility of the feeding specialist/ team. Strict compliance with the feeding protocol must be emphasized in staff training, with periodic monitoring by the designated specialist. It is necessary to train at least two people who are familiar with the student to insure the availability of a feeder every day. Trained feeders are required to sign that they have received training in the protocol, and agree to implement it as directed by the feeding team. To maintain proficiency, it is recommended that a feeder feed the child at least once per week. This also provides the child with a variety of feeders so they don't become dependent on just one person.

Specialists who are well trained and highly experienced in safe feeding techniques should be responsible for training. He or she should be competent in handling and positioning children with neuromuscular disorders, be skilled in assessing oral-motor dysfunction, and have the ability to develop and implement an appropriate feeding program. In addition to demonstrating technical expertise, the specialist should be skilled in and comfortable with the training of others. Physical therapists, occupational therapists and speech/language pathologists are expected to follow professional guidelines when training others, which are set forth in their practice acts. Training that is documented and then periodically reviewed allows for consistency in program implementation and identifies additional training needs. See page 41 for a suggested training sequence.

Some procedures must be taught and monitored by a nurse as defined by the Nurse Practice Act. “Delegation” means that a registered nurse authorizes an unlicensed person to perform special tasks of client/nursing care in selected situations and indicates that authorization in writing. The law specifies which tasks fall under this designation. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed person, teaching the task and insuring supervision and follow-up training.

Responsibilities of the Trainee:

No person should ever undertake the feeding of a child with a feeding disorder without appropriate training by a licensed specialist. The trainee has the responsibility to carry out the child’s feeding program as directed and monitored by the specialist. It is the responsibility of the trainee to:

- Read and frequently review the Safe Feeding Checklist;
- Have available any adapted/specialized equipment the child may use;
- Read and frequently review the student’s written Feeding Protocol and Emergency Plan;
- Inventory and maintain equipment;
- Problem-solve with the staff any issues that may be anticipated to impact the feeding program, (e.g., comfort level of feeder, staff time and schedule constraints, ability of staff to maintain program consistency);
- Make sure that others are available to help if an emergency should arise. Feeding should never occur in isolation.

Safe feeding may begin when the person feeding the child meets the recommendations listed below:

- The feeder demonstrates proficiency in the feeding protocol and has been signed off by the feeding specialist/team.
- The feeder is knowledgeable in general Guidelines for Facilitating Safe Feeding (p. 49).
- The feeder knows the specific feeding needs of the individual student.
- The feeder is current in CPR and abdominal thrusts.
- Training is routinely monitored by professionals.
- The feeder recognizes when modification of current feeding practices is needed and notifies designated specialist for direction.
- The feeder is backed up by an equally knowledgeable and trained replacement.
- The feeder is aware when additional consultation is needed.
- The feeder recognizes that the feeding plan and correct feeding practices can only be modified by the specialist.

Monitoring of Mealtime Programs and Feeding Protocols:

Feeders should be trained until they demonstrate proficiency in the feeding protocol and are comfortable with procedures and emergency protocols. In addition to the initial training of staff members in safe feeding, regular ongoing supervision on the part of the responsible specialist is necessary to insure safety. After the period of initial training, monitoring should take place on a regular schedule, (i.e., weekly, bi-weekly, monthly) at the discretion of the feeding specialist/team, but at least yearly. The **Observation of Trained Feeder** form, provided in **Sample Forms and Protocols**, may be used to document observation of staff who feed students. The protocol should be updated at least annually.

Monitoring of a student's feeding program should include consideration of questions such as the following:

- Have the student's oral-motor, posture or feeding skills changed?
 - ✓ Is the child still on their growth curve?
 - ✓ Have there been changes in the child's eating or posture?
 - ✓ Has the child experienced any significant changes in medical history?
 - ✓ Has the child recently had surgery or a medical episode that may change muscle control or positioning?
 - ✓ Has the child's seating system (wheelchair or other seat) changed?
- Is the protocol being followed?
 - ✓ Is it still effective?
 - ✓ Do changes need to be made?
- Feeding environment for the student:
 - ✓ Is it safe?
 - ✓ Is it socially appropriate?
 - ✓ Is it free of distractions?
 - ✓ Is it sanitary?
- Is the staff comfortable with the feeding protocol?
 - ✓ Are staff questions being solicited and answered?

The specialist must plan to periodically retrain all staff who are doing feeding to insure the necessary techniques and procedures are fresh in their minds. Of course, any change in the child's ability to chew or swallow, physical growth or changes, change in alertness, seizure status, etc., since the feeding protocol was initiated, should be called to the attention of the responsible specialist and should receive prompt attention.

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DEVELOPING A DISTRICT PROCESS TO ADDRESS FEEDING

As educational programs work to develop a process for assessing children with feeding difficulties and designing programs to meet their unique needs, the following questions come under consideration:

- How will referrals be made to the feeding team?
- What resources are available within the school district and where will interagency coordination be necessary?
- Who will determine whether further medical information is needed?
- Who is qualified to interpret medical reports?
- Who will be responsible for developing feeding protocols?
- How will feeding procedures and diet plans be included in the IEP/IFSP?
- Who will implement staff training of mealtime plans?
- How will follow up and reevaluation of feeding protocols be assured?
- What steps should the district take when it's determined that a child cannot be fed safely at school?
- What are the emergency protocols?

These are just some of the complex issues which must be considered in determining an appropriate program for any given student. Each local education agency must make decisions about how to handle these questions.

The role of the feeding team is to evaluate students who have eating problems and to develop mealtime plans in collaboration with the child's IEP/IFSP team. Feeding teams also work with special education administrators to develop a district process which considers the district's legal mandates and liability issues.

As with any evaluation for a child on an IEP/IFSP, a feeding evaluation must be conducted in accordance with IDEA. It is critical that the administrator be a part of the decision-making process when issues of student safety are involved. Communication between the feeding team and program directors is essential to insure that the district does not commit to a course of action without administrative approval. For these reasons, it is important for school programs to develop processes and procedures for referral, evaluation, plan development, implementation and continued support and monitoring by the feeding specialist/team.

This chapter outlines the steps involved in referral and evaluation of children who are at risk for feeding problems. The summary of the main components of the process, on the following page is followed by a narrative explanation of each component.

Sample forms are included throughout the text to flag points within the process where a form may be needed. Titles are noted in bold. Blank copies of those forms have been provided in the section entitled, ***Sample Forms and Protocols***. Examples of completed feeding protocols are also included in this section. Again, these protocols are meant only to serve as examples of what an individually designed protocol might look like for a given child.

The last page of the ***Sample Forms and Protocols*** section includes the ***Planning Checklist*** which is a tool for use in developing a district referral process. It may also be used as an instrument in evaluating existing procedures to insure inclusion of critical components.

Summary Components of a Process for Referral and Evaluation by the Feeding Team

1. Feeding Team Members are assigned and a regular meeting time established. Agency staff are informed about the team, criteria for referral, and the procedures for requesting a feeding evaluation.
2. Permission to Evaluate and Release of Information forms are sent to the child's parent for signature permitting the referral for evaluation and for releasing information to be obtained from medical or other sources.
3. Referral received by Feeding Team: Initial information is shared at the regularly scheduled meeting of the Feeding Team, the referral is documented and a case manager is assigned.
4. When permission is received, the Feeding Team case manager sets up a time for observation and file review.
5. Observation takes place and anecdotal data is recorded.
6. Form for documenting feeding concerns is given to teacher and parent.
7. Further observation by additional Feeding Team members takes place, if needed.
8. Further evaluation by medical or other outside resource is recommended, if needed.
9. An alternative plan is developed if the parent or physician refuses to have additional medical evaluation performed, or if the results of the evaluation prohibit the child from being fed orally at school.
10. Recommendations are made to the school-based educational team and a feeding plan is developed and included in the student's IEP/IFSP.
11. Staff is trained and follow-up reviews planned on a schedule decided by the Feeding Team.

1. Feeding Team members are assigned and a regular meeting time established. Agency staff are informed about the team, criteria for referral and the procedures for requesting a feeding evaluation.

The Feeding Team is comprised of individuals who are knowledgeable about safe feeding for children with special health concerns. The team may include the speech-language pathologist, occupational and physical therapists, a nurse, a registered dietician, a special education teacher, and others knowledgeable about feeding and swallowing disorders. While there may be some overlap in knowledge among the team members, each discipline brings unique training and expertise to the task of the feeding evaluation. The following page shows a listing of the special expertise that each discipline brings to the team.

Feeding Teams may choose to meet on a regular basis (i.e. monthly) or only when a referral for evaluation is made. When the school district does not employ all the essential members of a Feeding Team, it may be necessary to contract with another local agency to provide the expertise needed. Education Service Districts, regional programs, community health programs or local hospitals are potential resources for interagency cooperation.

The team works with administrators to develop procedures for making agency staff aware of the team, its criteria for referral, and procedures for requesting an evaluation by the team.

Contributions of Various Disciplines to Feeding Team Expertise

Registered Nurse

Liaison with the medical community, interpretation of medical records, need for additional medical evaluation, impact of medications and medical conditions on the child's eating and safety. Ability to legally delegate, train and monitor associated nursing tasks.

Registered Dietician

Provides consultation on growth gain parameters, adequacy of nutrient intake and recommended medical nutrition therapy plan; may work with the school kitchen staff to provide special foods or special consistencies.

Occupational Therapist

Knowledge of fine motor skills needed for self-feeding, sensory-motor aspects of eating, adaptations and modifications to feeding equipment.

Parent or Caregiver

Background information on current home practices at mealtime, medical and birth history, other information about the child. For the EI child, the parent takes a more active role on the feeding team as the primary feeder.

Physical Therapist

Expertise in positioning and its impact on feeding.

Special Education Administrator

Knowledge of district responsibilities under the Individuals with Disabilities Education Act (IDEA), ability to allocate funds for outside referrals or special equipment, and to coordinate services from other agencies as needed.

Special Education Teacher

Understanding of the child's cognition, learning needs, and level of ability to actively participate in the feeding activity; knowledge of the child's daily routine.

Speech-Language Pathologist

Knowledge of oral-motor function and therapeutic approaches to training new feeding skills. Expertise in developing a communication systems/process for the child during feeding, as well as throughout the child's day.

Child's Teacher

Knowledge of student's behavior, school schedule, culture and routines, designation of classroom resources.

Other Specialists as Appropriate

Consulting Teacher, Behavior Specialist, etc.

2. Permission to Evaluate and Release of Information forms and parent questionnaires are sent to the child's parent for signature permitting the referral for evaluation and for information to be obtained from medical or other sources.

Parental notification and signed consent, as mandated by special education law, should be completed prior to any referral for evaluation. This process is the same as the process used to gain permission for an intellectual evaluation. The educational team uses the district's **Prior Notice About Evaluation** form. A sample of the form recommended by the Oregon Department of Education's Office of Special Education is included under **Sample Forms and Protocols**.

Because feeding is an issue which is very important to families, the educational team may want to send a cover letter describing the reasons why a feeding evaluation is desired and why permission is needed. If for any reason, the parent has not been a part of the team process up to this point, the teacher or other school contact person, should telephone the parent in advance to discuss the referral. This allows the parent to ask questions, and may prevent undue concern on the part of the parent about the process. A sample of a letter to a parent regarding a feeding evaluation is included on the following page.

Should the team require medical records or a conversation with the child's doctor, a district form requesting permission to release and exchange information, such as the **Permission to Release Information** form is sent to the parent for a signature. Some medical facilities require the use of their own form for this purpose.

Sample Parent Letter

Date _____

Dear parent:

This is a follow-up letter to our conversation regarding our concerns about _____'s eating. In that conversation, I recommended a feeding evaluation by the Feeding Team. The purpose of the evaluation is to develop a feeding plan to ensure that your child eats as safely as possible at school.

The feeding evaluation would be comprised of three parts: a review of records, interview with you and school staff who help your child at lunch time and observations of your child eating at school. You may be asked to sign a Release of Information form, permitting the team to contact your child's doctor for medical reports. The team may make trial modifications to seating, adaptive equipment, or the environment as a part of the assessment.

As part of the educational team, you will be included in planning the evaluation and in developing the final feeding plan for your child, based upon the results of the evaluation.

As we discussed, the feeding evaluation was recommended for your child because _____ (summary of feeding concerns).

When this evaluation is completed, we will have additional information about her eating difficulties, and what to do to improve her safety when she eats at school.

I am enclosing a "Prior Notice about Evaluation" form for you to sign and return to me. Your signature allows us to refer your child to the Feeding Team and to share information with them. I am also enclosing a copy of the "Parent Rights Under IDEA" pamphlet, which explains that you may refuse an evaluation at any time if you so desire. Please call me at _____ if I can answer any additional questions about the evaluation.

Sincerely,

Enclosures: Prior Notice About Evaluation
 Parent Rights Under IDEA

3. Referral received by Feeding Team: Initial information is shared at the regularly scheduled meeting of the Feeding Team, the referral is documented and a case manager is assigned.

Referrals may originate with the student's parent, teacher, therapist, or another adult when there is reason to suspect that a child has a feeding or swallowing disorder. Children may also be referred to the Feeding Team when they are considered to be at risk for feeding-related problems due to a changed health condition or other circumstance. This could be a result of a diagnosis of a seizure disorder, a change in medication affecting the child's level of alertness, a change in seating such as a new wheelchair, or observation of a change in the child's behavior. A newly enrolled student whose IEP/IFSP includes a feeding protocol would also be referred to the team for evaluation to ensure that the plan is still appropriate and can be implemented at the new school. Information needed at referral would include the child's age, educational placement, diagnosis of disability, medical history and current status (including allergies and current medications) and of course, the reason for referral. Referral questions may cover such topics such as how best to position a child for feeding, what modifications of feeding utensils might help a child to meet a self-feeding goal, and what to do if a child has a seizure while eating in the lunchroom. It is useful to document this information using a standardized form developed by the team, such as the ***Referral for Feeding Evaluation Form***. A sample of a referral form, which has been completed for an individual child, is presented on the following page.

Based upon the referral information, members of the Feeding Team decide who will act as primary case manager for the purpose of the feeding evaluation and any follow-up activities. The case manager oversees the evaluation process, communicates with the parents or teacher, and sees the process through to its completion. For example, if the primary concern is related to positioning, the physical therapist may be assigned to be the case manager. If the reason for referral is a need for medical information, the nurse may take the lead role in the evaluation.

FEEDING REFERRAL

Date: 10/13/14 Student: Jane Doe DOB: 11-12-03

Regionally Eligible? Yes ☒ No ☐ School Anywhere Elem. Grade 5 Teacher Smart

Address 123 Applegate Valley Rd., Anywhere, OR

Parent Name(s) John & Janet Doe Parent Telephone 123-4567

Primary Physician/Pediatrician Jill Smith, M.D. Phone 123-8901

Referring Person Sam Smart, DLC Teacher

Reason for Referral/Specific Problems Eats very slowly. Lunch takes 1 hour.

Seizures and fatigue interfere with feeding.

Sam Smart
Referring Staff Member Signature

Bob Jones
Principal Signature

Medical History

Primary Diagnosis CP (Spastic Quadriplegia)

Secondary Diagnosis Seizure Disorder

Cognitive Function Not able to test

Alertness/Attention Drowsy, frequent seizures

Language Comprehension Minimal expressive communication

Visually Impaired No, but does not use Hearing Impaired No

Parent Impression of Swallowing/Feeding Difficulties Concerned that Jane isn't getting

adequate calories, worried about nutrition & health status

Respiratory Status Frequent congestion & coughing

History of Aspiration/Pneumonia Hospitalized for pneumonia 2/92, 1/96

Reflux or Regurgitation Rarely noted

Tube Feeding ☐ Oral feeding ☒ Combination ☐ Was the child ever an oral or g-tube feeder? No

Allergies None known

Medications

Name and Dosage Depakote 125 mg. sprinkle on first bite of food, 3x daily

Nutritional and Dietary Status

Calorie Intake Nurse is assessing

Fluid Intake Average 3 oz. with meal

Summary of Past Feeding Difficulties Mother reports difficulty with feeding as an

infant, bottle-fed until age 4. Remedial feeding program w/ OT consult 30.min. 2x monthly

4. **When permission is received, the Feeding Team case manager sets up a time for observation and file review.**

The team case manager contacts the child's parent or school to identify a time and place to observe the child eating in his/her typical environment. A review of the child's file also takes place as a part of the collection of background information. Medical history and previous recommendations for treatment, are noted along with IFSP/IEP feeding goals and any other pertinent information.

A thorough **Nursing Assessment**, one in the **Sample Forms and Protocols** section, should be conducted when gathering medical information. A form such as this is recommended for documentation of the **Nursing Assessment**.

5. **Observation takes place and anecdotal data is recorded.**

As team members observe the child, they record their observations using a form designed to look more closely at the child's feeding, such as the attached sample, entitled, **Observation of Feeding in School**. This observation notes factors such as the environment where feeding takes place, the actions of the person feeding the child, cues or prompts used, characteristics of the food being given, and the child's behaviors before, during and after feeding.

OBSERVATION OF FEEDING IN SCHOOL

Name Jane Doe DOB: 11-12-03 Teacher Sam Smart
 Date of Observation 10-26-14 Evaluator Ray Rowe, OTR
 Cognition/Attention/Pacing Drowsy, semi-dozing (See Brazelton Scale) Feeder attempted to gain attention via verbal prompt: "Jane time to eat" plus touch signal to back of hand.
 Positioning Seated in reclined position in wheelchair w/trunk supports, head -rest
 Child's Communication Methods Receptive: Verbal prompts, plus touch signals
Expressive: Facial Expression, coloration, body posture
 Precautions Observe for seizure activity, stopped feeding for seizures, resumed feeding shortly afterward.
 Utensils Equipment Small, rubberized spoon, cut-out plastic cup

 Consistency/Textures Thick puree of school lunch
 • Oral Defensiveness Moderate
 • Temperature Warm
 • Taste Classroom staff state spicy food upsets her stomach
 Liquids: Thin Not given Thickened to nectar consistency
 Food Likes and Dislikes Likes ice cream

 Allergies No known allergies
 Feeding Procedures (Time, Methods, Approach) Feeder gave verbal prompt, delivered bites of food to roof of mouth, scraping spoon off on upper teeth. Waited while J. moved food to back of throat via tongue thrusts. Gave drinks at intervals.
 Unusual Feeding Methods Tilted back in chair with chin up to open throat
 Oral Care after Feeding Drink given at end of meal, Toothettes used to cleanse food from teeth and gums
 Postprandial Distress Food build-up on roof of mouth, J. unable to remove completely
 Tolerance to Oral Care: No Problem x Defensive _____ Explain J. appeared to tolerate well.
 Recommendations: Immediate action: Discontinue reclined position, place neck roll behind head for chin tuck. Institute 1/2 hour break post-seizure. Feeder sit below J. to view upper palate. Institute use of Safe Feeding Checklist prior to feeding. Complete full Feeding Team evaluation.

6. Form for documenting feeding concerns is given to teacher and parent.

Family members and teaching staff who feed the child are encouraged to record anecdotal information about each day's feeding using a form such as the sample on the following page entitled, **Daily Feeding Log**. The feeding log establishes data as to the frequency and type of problems experienced by the child during feeding on a daily basis. This data can form a critical part of the team's evaluation.

7. Further observation by additional Feeding Team members takes place, if needed.

Upon review of the information collected in the initial referral, review of records, feeding observation and feeding log, the team determines what additional information is needed to identify and prescribe a protected feeding protocol for the child. The team identifies which team members are most appropriate to perform the next step in the evaluation of the child's feeding. For example, if there are concerns about the child's oral-motor function, the speech-language pathologist may be asked to observe. If there are questions about positioning or sensory issues, the physical therapist or occupational therapist may be requested. If concerns revolve around respiration or other health-related issues, (e.g. seizures, choking, vomiting,) the nurse may be asked to see the child. Frequently two or more team members will go together to jointly observe the child. An instrument such as the **Standard Oral Motor Evaluation** form or the **Infant and/or Severely Neurologically Involved Oral Motor Evaluation** form may be used to guide the observation.

The team members look at all aspects of a child's feeding. They take note of the child's physical characteristics such as muscle tone, head control, respiration patterns during feeding, tactile defensiveness, oral-motor reflexes, and how the child manages his/her saliva. Cognitive aspects, such as alertness, responsiveness, developmental level, communication modes; and environmental factors, such as sensitivity to sounds, distractibility or orientation to peers are all among the variables that are considered in a feeding evaluation. Positioning and seating are evaluated by the physical and occupational therapists, with consideration for the child's comfort, safety and optimal function. Food temperature, texture, and taste are noted to determine whether these affect the child's ability to eat safely. For example, many children with reduced sensation are better able to swallow food that is cold. Varying consistencies of foods and liquids may be tried to identify which ones the child is best able to manage and swallow. Data on the child's weight, height and caloric intake may be taken in order to determine how feeding problems are affecting health and physical development. Again, the classroom staff may be asked to keep a feeding log to document how the child eats on a day-to-day basis, making note of any unusual events.

DAILY FEEDING LOG

Student Jane Doe DOB 11/12/03 School Anywhere Elementary

FEEDING REMINDERS

1. Check Daily Feeding/Swallowing Protocol for setup, precautions prior to feeding.
2. Do not feed the child in isolation. Always have backup in case of emergency.
3. Make sure glasses are on and hearing aids are in place.
4. Keep child in upright position for 20 minutes after feeding.
5. **Contraindications for feeding.** Document and do not feed present meal if the child . . .
 - a. is having a seizure,
 - b. coughs, gags, chokes frequently during feeding,
 - c. has increased congestion or drooling,
 - d. is sleepy or is not alert,
 - e. appears ill or has fever, fatigue, or vomiting,
 - f. attempts many swallows without success,
 - g. has difficulty breathing,
 - h. has unusual skin color, i.e., pale, gray, or bluish tinge,

	Specify	% of Meal	% of Liquids		Food Consis-	Liquid Consis-		
10/27/99	lunch	75%	50%	Pizza	puree	fruit nectar	Ate well	DR
10/28	lunch	75%	75%	Corn dogs	puree	nectar	Good eating!	BL
10/29	lunch	50%	50%	Tacos	puree	nectar	Seizure, coughing	CJ
11/30	ABSENT	-----	-----	-----	-----	-----	-----	-----
11/2	lunch	50%	50%	Toasted Cheese	puree	rice milk	Fatigued, coughing	BL
11/3	ABSENT	-----	-----	-----	-----	-----	-----	-----
11/4	lunch	50%	50%	Sloppy Joes	puree	nectar	Coughing	DR
11/5	lunch	75%	30%	Goulash	ground	juice	Difficulty w/jc	BL
11/8	lunch	50%	75%	Sandwich, corn	puree	rice milk	Didn't like	CJ
11/9	lunch	50%	50%	Chili, corn bread	puree	rice milk	Delayed (seizure)	DR
11/10	lunch	100%	Nut	Butter shake with rice	milk		Drank all!	BL

8. Further evaluation by medical or other outside resource is recommended, if needed.

When the team determines that they do not have enough information about a child or when there is conflicting information, they may wish to obtain an evaluation from an outside source before establishing a protected feeding plan. For instance, if something about the child is noted during the feeding observation, such as a change in skin tone or increased congestion during feeding, a medical assessment of the child's ability to manage and swallow food would be indicated. Further evaluation may include, but would not be limited to, a medical examination such as a video x-ray of the child's swallow, known as a videofluoroscopy or swallow study. The referral is made via the parents to the child's primary care physician, with signed permission from the parents for the school team to communicate with the doctor about their concerns.

Several things may happen if a child is referred for a video swallow study by their medical provider:

- a) the parent must sign consent for the study to be performed;
- b) the parent may refuse to have the swallow study performed;
- c) the study finds the child safe for eating orally and recommendations for safe feeding are made to the team;
- d) the study finds the child is unsafe to eat orally and recommendations are made for an alternative plan.

An interim plan is needed until evaluation by the medical agency is completed. The plan should be developed by the IEP/IFSP team, with the Feeding Team, to provide for the child's nutritional and hydration needs while waiting for medical information. For example, the team may decide to have the child attend school on a modified schedule to enable him/her to eat at home before and after school. This would constitute a change in program requiring a revision of the IEP. Another alternative might be to have the child drink a specially thickened milkshake in place of eating lunch at school. A damp washcloth or "Toothette" may be recommended to moisten a child's mouth when he is prevented from drinking orally for reasons of safety. Alternatively, the team may determine that the best course of action is to provide home instruction for the interim period. This would qualify as a change in placement, requiring notification and IEP revision. An interim plan must be designed to meet the unique needs of the individual child, given what is known up to that point about his/her feeding abilities, nutritional needs and family preference, within the context of the school program. The interim plan will be in place until a decision is made by the Feeding Team that the child is safe to feed orally at school. A sample interim or alternative plan is shown on the following page.

ALTERNATIVE PLAN

To be attached to the IEP

Student: Jane Doe

Date: 11/23/14

Placement: DLC classroom, Anywhere Elementary School

Support/Procedure/ Service:

1. Jane will attend school between the hours of 10:00 and 2:00
2. Jane will be fed meals at home, before and after school.
3. While at school, comfort measures will be given as follows:
 - a) Moist washcloths applied to lips and inside of mouth
 - b) Moistened Toothettes used to stimulate inside of cheeks and gums, and to clean mouth.
 - c) Apply ointment to lips
4. Call parents if Jane shows signs of thirst which persist after routine care.

Schedule/Frequency:

Moist washcloths, 2x daily during school day

Toothettes one time daily at noon, and as needed to freshen breath

Ointment as needed to moisten lips

Responsible Staff:

DLC classroom staff

Monitoring and Documenting Procedures:

1. The Daily Feeding Form form (of the state Feeding Manual) will be used to record activities daily.
2. School nurse will visit classroom weekly to monitor program and provide information and consultation to classroom staff.

Participants in planning meeting:

General Education Teacher: _____

Special Education Teacher: _____ Parent(s): _____

District Representative: _____ Other/Title: _____

Other/Title: _____ Other/Title: _____

Other/Title: _____ Other/Title: _____

9. An alternative plan is developed if the parent or physician refuses to have additional medical evaluation performed, or if the results of the evaluation prohibit the child from being fed orally at school.

It is the parent's legal right to refuse to allow their child to be evaluated, either by the Feeding Team or by an outside source, such as a doctor. Should parents refuse to have their child evaluated, it is the responsibility of the school Feeding Team to work together with the parent and the IEP/IFSP team to develop an alternative plan, (like the *interim plan* discussed in step #8,) to enable the child to benefit from his/her special education program. This document would be attached to the student's IEP/IFSP. In the case of a child on a 504 plan, the alternative plan would be a part of the plan developed to enable the child to attend the school program. There may be a case where the team has determined that the child is unsafe to be fed orally at school. This may be due to a medical evaluation which shows that the child is at risk for health problems when eating orally. Alternatively, it may be due to the absence of an evaluation when the team has grave concerns about a child's safety. Again, the team is responsible to make every effort to accommodate the child within his/her school program without putting the child's safety in jeopardy, or the school at risk of liability. For a child who has a gastrostomy tube (g-tube), an alternative plan may involve training by a nurse to give the child g-tube feedings at school. In the absence of a g-tube, the child's schedule may be modified to enable him/her to attend school for a shortened day without needing to have a meal or a drink at school. The nurse, in conjunction with the rest of the Feeding Team, works to develop an alternative plan which meets the needs of the child as shown on the previous page.

In a case where there is a difference of opinion between the parents and the school about whether a child should be fed at school, it is recommended that a written statement be sent to the parents stating the decision of the school, why that decision has been made, and offering to meet with the parents to discuss the decision further. It is critical that the administrator be involved in this decision.

If, in the opinion of the team, a child's health and safety are being routinely compromised, it is recommended that those concerns be resolved before the child is allowed to eat at school.

10. Recommendations are made to the school-based educational team and a feeding plan is developed.

When the results of the feeding evaluation indicate safe methods for feeding, a feeding protocol is developed for attachment to the child's IEP/IFSP. The Feeding Protocol should contain a plan for staff training, documentation or data-keeping, and ongoing monitoring by the feeding specialist/team. A format such as the **Daily Feeding Protocol** is used to document the protocol and may be signed by the parent at an IEP/IFSP review to indicate that the parent has participated in developing the plan for feeding their child. Other information such as the **General Guidelines for Safe Feeding** (see **Resources**) may be given as part of the staff training. The designated feeder may be asked to use a daily feeding log or the **Safe Feeding Checklist** to document concerns or events that may occur during adherence to the feeding protocol.

11. Staff is trained and follow-up reviews planned on a schedule decided by the Feeding Team.

When a feeding protocol has been developed, school staff must be trained in its implementation. Training is provided by the Feeding Team member or members having the most expertise about the child and his/her unique feeding needs. Ideally, training would include this suggested training sequence:

Suggested Training Sequence

- a. Specific inservice training, which includes a review of the written feeding protocol, presented by the specialist.
- b. Demonstration of the feeding protocol by the feeding team.
- c. Hands on experience by the feeder under the supervision of the trained specialist.
- d. Training should continue until the feeder demonstrates proficiency. Feeders sign the protocol indicating that they have been trained and agree to implement the student's written protocol as directed by the feeding specialist/team.
- e. **Observation of Trained Feeder** form to be completed at each observation by feeding team or by designated school team member. Copies of the form are distributed, with (at minimum) the original going to the feeding team supervisor, one to the trained feeder, one for feeding team records.
- f. At the beginning of each school year, training and/or a refresher to be completed by feeding team or designated school team member.
- g. Periodic review of the written feeding protocols for the assigned student by the feeding team, at least annually.
- h. To ensure effective and safe feeding programs, monitoring should take place on a regular schedule. The feeding team should plan occasional "drop-in" visits to ascertain that the feeding protocol is followed at all times.

The **Feeding Training and Monitoring Log** is another instrument which may be used in documenting training and follow-up review. Under IDEA, children having feeding goals on their IEP/IFSP require review of these goals and progress reports on the same schedule as their same-age peers.

A Final Word...

This has been a discussion of the issues involved in developing a district process for referral and evaluation of students who have special feeding needs. Each school district will develop their own procedures for the process, contingent upon their local model of service delivery, resources, geography and the many other factors that come under consideration. Forms suggested in this guide are to be regarded merely as examples and are in no way to be considered mandated for use.

The basic elements of any district process, identified in this document will generally remain the same across school districts. These components are listed in the form of a worksheet entitled, **Planning Checklist**. The checklist is designed as a tool for school districts to use as they develop their own procedures for referral and evaluation of students by the Feeding Team. The checklist may also be useful for established teams to use in evaluating their existing procedures to insure inclusion of critical components or to clarify areas of confusion.

Schools today face a myriad of challenges from all sides. Educators are daily confronted with what seem like ever-higher hurdles between themselves and their ability to provide effective educational services to children. We are continually amazed, refreshed and inspired by the dedication and vigor of the professionals we meet in school programs throughout the state. It is our hope that this document will assist school districts as they struggle with the complex and important challenge of feeding children safely in school.



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RESOURCES

1. Risk Factors
2. Health Factors that Affect Feeding
3. General Guidelines for Safe Feeding
4. Textures Taste Temperature
5. Consistency Tables for Liquids (Beckman Oral Motor, Inc.)
6. Thickened Shakes
7. Calorie Boosters & Nutrition Ideas
8. School Age Prior Notice about Evaluation Consent for Evaluation
9. Medical Statement or Health Assessment Statement
10. Medical Statement for Birth to Age 3
11. CDRC Release of Information - Spanish
12. CDRC Release of Information – English
13. Shriners Authorization for Disclosure of Health Information
14. Resources in Oregon
15. References

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High Desert Education Service District

REGIONAL SUPPORT SERVICES

520 NW Wall Street • Bend, OR 97701 • 541-693-5700 • FAX 693-5701

RISK FACTORS INDICATING POSSIBLE SWALLOWING DYSFUNCTION

Name
Evaluators

Birthdate
Evaluation Date

Clinical signs, which may occur alone or in combination, are:

	YES	NO	?	COMMENTS
1. Excessive drooling				
2. History of pneumonia, allergies, wheeze or asthma				
3. Wet, gurgling voice sound during or after eating				
4. Coughing, choking, throat clearing during/after eating				
5. Nasal/gastro esophageal reflux				
6. Apnea or cyanosis				
7. Food pocketing or residual food in mouth				
8. Abnormal or absent sucking or chewing				
9. Limited voluntary movement of tongue, lips or cheeks				
10. Difficulty swallowing; Delayed or absent swallow trigger reflex				
11. Tongue thrust				
12. Multiple swallow				
13. Feeding takes longer than ½ hour				
14. Weight loss or underweight				
15. Decreased head/trunk control				
16. Abnormal muscle tone (exceptionally low or high)				
17. Diminished responsiveness or alertness				
18. Requires special positioning or equipment				
19. Frequent irritability				
20. Fear or reluctance toward food				
21. Difficulty holding food in mouth				
22. Chronic constipation				
23. Congestion				
24. Presence of seizure disorder				
25. Poor growth				
26. Poor general health				

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Health Factors that Affect Feeding

Failure to thrive due to:	Feeding problems due to:	Obesity due to:
<p>oral-motor dysfunction,</p> <p>high energy requirements,</p> <p>activity,</p> <p>fatigue,</p> <p>dehydration,</p>	<p>oral-motor dysfunction,</p> <p>child's behavior,</p> <p>dysfunctional parent/child interactions related to feeding</p>	<p>immobility,</p> <p>limited activity,</p> <p>gastrostomy</p>
Diarrhea/Constipation due to:	Drug/Nutrient interaction due to:	Allergies due to:
<p>abnormal anatomy/neurologic function of the intestinal tract,</p> <p>abnormal muscle tone,</p> <p>inactivity due to prolonged illness, immobility or paralysis,</p> <p>inadequate fluid/fiber intake,</p> <p>ineffective toileting habits,</p> <p>certain medications,</p> <p>food types presented</p>	<p>gastrointestinal disturbance,</p> <p>anorexia,</p> <p>increased appetite,</p> <p>decreased consciousness,</p> <p>interference in metabolism</p>	<p>foods,</p> <p>drugs,</p> <p>type of reaction, i.e., anaphylactic reaction</p>

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General Guidelines for Safe Feeding

1. The child should be evaluated for positioning during feeding in a way that addresses his/her disability and provides maximum success in feeding. This includes good support of the trunk. Feet should be supported on the floor or footrests of wheelchair.
2. Head should be in midline with head slightly forward for greatest ease in swallowing.
3. If the child wears glasses or a hearing aid, these should also be worn during meals to maximize environmental cues.
4. If the child uses an alternative means of communication, this should be used during the mealtime with appropriate cues. Talk the child through the feeding procedure, using appropriate verbal, manual or visual cues.
5. Allow sufficient time for eating. Pacing is extremely important and the child should never be rushed. Watch for facial or body cues when feeding a child, including a completed swallow (the larynx will move upward), and do not offer more food until this has occurred.
6. Minimize outside distractions. Allow the child to concentrate their full attention on the swallowing process. Do not allow yourself or the child you are feeding to become distracted by other students or classroom activities.
7. Avoid milk products and other foods that increase the child's mucous level. Also, avoid sticky foods that are difficult to swallow such as mashed potatoes, fresh white bread or peanut butter.
8. Never use any spoon larger than a teaspoon and avoid metal spoons. Food should be taken in small bites/sips, as chewing and swallowing movements are often slow or reduced. Allow ample time to swallow each bite.
9. Be sure the child has completely swallowed the food before placing more in their mouth. Every three to four bites, check to be sure the child is swallowing the foods completely so they are not packing food into their cheeks and oral cavity.
10. Thoroughly check the child's mouth during and after the meal. Food may tend to collect in cheeks and could be aspirated later if not cleared.

11. Monitor the child's fatigue level while eating. If child is easily fatigued, add a resting period prior to feeding to increase energy level.
12. If the child becomes too fatigued to eat, discontinue feeding. Check with the feeding specialist regarding the amount of time and energy it takes for feeding for individualized guidelines regarding the student.
13. If there is evidence of frequent coughing and/or choking and/or nasal regurgitation, discontinue the oral feeding.
14. Do not force the spoon into the child's mouth. Wait for the child to open his/her mouth or gently assist by applying light pressure downward on the chin.
15. Let the child's mouth completely close around the spoon; this will stimulate the swallowing reflex. Do not scrape the spoon off on the child's teeth or gums.
16. Attempt to remind the child to keep their mouth closed while chewing, sucking, and swallowing. This will discourage poor patterns, such as tongue thrusting and drooling of food substance and/or saliva.
17. Coughing is a protective mechanism to avoid choking or aspirating. Should the child begin coughing while lying down, you may need to assist the cough by bringing him/her to a sitting position with the head slightly tilted forward.
18. Provide good oral hygiene after each meal. After brushing toothettes may be helpful in removing food particles that may have been pocketed in the sides of the mouth.
19. Never leave the child alone to eat.
20. Be prepared to handle airway obstruction by being training in CPR and abdominal thrusts. If the child is in a wheelchair or is wearing a body brace, get special instructions from a medical specialist that may include the physical therapist.
21. Continue to maintain the child in an upright position for a period of one half hour after eating to observe for possible reflux aspiration, unless otherwise specified by the child's medical provider.

Considerations for Texture, Temperature, Taste and Smell

Textures

Consistencies of liquids and foods vary starting with **liquids** which can be anywhere from **thin**, such as water or **thick** like a milkshake or a thick nectar. Nectar consistency is like that of tomato juice. Descriptions of textures is an important part of the feeding protocol and should be reviewed with staff periodically for clarity. The texture may be varied by decreasing or adding more liquid such as broth, juice, water or milk.

Thin liquids may be more difficult to swallow due to the viscosity and rate of flow that increases the volume entering the oral cavity requiring the child to swallow more quickly. This may pose a major problem for children with difficulty coordinating their breathing and swallowing.

Descriptions for liquids include:

Thin- water, boxed juices

Liquid- milk, formulas

Medium- Fruit nectars, honey, syrup

Thick- Milk shakes

Puréed foods may have the consistency of a pudding or yogurt and require no chewing. A **thin puréed** food is smooth, wet and slippery as opposed to a **thick purée** such as smooth peanut butter or mashed potatoes with no lumps. Puréed foods move more slowly than a liquid, thus allow the child more time to coordinate their swallow. Descriptions of puréed foods include:

Thin puréed- Smooth, wet, slippery with some cohesiveness, such as applesauce

Puréed- Smooth and moist with good cohesiveness, such as pureed bananas, squash or Mashed potatoes

Thick puréed- Smooth with little moisture, sticky like peanut butter

Textures also vary when there are lumps such as with crackers, vegetables, rice or ground meat added to puréed foods. When more texture is added, foods will vary in moisture which will influence the child's ability to form a bolus and ability to swallow food safely. Dry foods such as crackers make it more difficult to form a bolus as they take a considerable amount of saliva to moisten. **Dry foods** should be avoided due to this reason. When training staff on an individual feeding protocol, texture and moisture should be clarified with the staff.

Soft mechanical foods are easy to chew and swallow with a softer texture. Meats are ground or minced to no larger than 1/4-inch pieces or pea-sized. Attention to moistness of the food should be reviewed with staff and the family to ensure enough liquid is added to assist in forming a bolus. These foods do require some chewing ability. Any vegetables or fruit added should be easily mashed with a fork.

Temperature

Other considerations when feeding children with swallowing difficulties includes **temperature**. Consideration for the temperature of foods and liquids should be discussed as part of the

training since they can affect swallowing. Cold foods may be alerting and actually help to trigger the swallow reflex to assist the child in taking in thinner liquids.

Food Tastes and Smells

The taste and smell of liquids and foods affects not only the ability to swallow, but can make a meal more pleasurable. Taste and smell preferences should be noted in the feeding protocol. While there is an emotional component to these senses, there is also a cultural influence to take into consideration. Nutritional intake may increase with foods that are more familiar to the child. Flavor and smell is a major variable when working on feeding. Taste includes sweet, sour, salty, bitter, spicy, a combination of flavors or a neutral flavor such as bottled water. Finding the right variation may improve the child's ability to eat and gain the necessary nutrition for growth and development.

Consistency Table for Liquids

Fluid Viscosity

Fluid viscosity is measured in centipoise (cp). Water is one cp. Tomato juice, the standard used on this chart for nectar consistency, is approximately 56 cp's. Often caregivers misjudge the thickness of a fluid, often making it 4 times thicker than nectar. A recipe for thickening the fluids of different types and temperatures is very helpful.

Fluid consistency is difficult to attain. A line spread flow test of viscosity may help to standardize the caregiver's preparation of fluid consistency. Below is one example of such a chart. The fluid was prepared by the caregiver at the mealtime using 8oz of fluid and an immersion blender.

CONSISTENCY TABLE FOR LIQUIDS

Compiled by: Susan Grant and Renee Hancock, January 1996
Wyoming State Training School, Lander, WY.

Thick-It in the yellow can was used for the thickener. The information in the following tables was based on 8 ounces of liquid, mixed in the blender, or with an immersion blender to avoid lumps.

LIQUID	TEMP	NECTAR	THICKER THAN NECTAR	HONEY	PUDDING
Water	Cold	1 3/4 oz.	2 oz.	2 1/4 oz.	2 3/4 oz.
Water	Warm	1 3/4 oz.	2 oz.	2 1/4 oz.	2 3/4 oz.

LIQUID	TEMP	NECTAR	THICKER THAN NECTAR	HONEY	PUDDING
Cocoa	Warm	1 1/2 oz.	2 oz.	2 1/4 oz.	2 3/4 oz.
Coffee	Warm	1 3/4 oz.	2 oz.	2 1/8 oz.	2 3/4 oz.
Milk	Cold	1 1/4 oz.	1 1/2 oz.	1 3/4 oz.	2 1/2 oz.
Milk	Warm	1 3/4 oz.	2 oz.	2 1/4 oz.	2 1/2 oz.

Consistency Table for Liquids

Grant and Hancock
Page 2

LIQUID	TEMP	NECTAR	THICKER THAN NECTAR	HONEY	PUDDING
Apricot Nectar	Cold	None Added	1/2 oz.	1 oz.	1 1/4 oz.
Apricot Nectar	Warm	None Added	3/4 oz.	1 oz.	1 1/4 oz.
Peach Nectar	Cold	None Added	1 oz.	1 1/4 oz.	2 1/4 oz.
Peach Nectar	Warm	None Added	1 1/2 oz.	1 3/4 oz.	2 oz.
Pear Nectar	Cold	None Added	1/2 oz.	1 oz.	1 1/4 oz.
Pear Nectar	Warm	None Added	3/4 oz.	1 oz.	1 1/2 oz.

LIQUID	TEMP	NECTAR	THICKER THAN NECTAR	HONEY	PUDDING
Apple Juice	Cold	1 3/8 oz.	1 1/2 oz.	1 3/4 oz.	2 1/2 oz.
Apple Juice	Warm	1 1/2 oz.	1 3/4 oz.	2 oz.	2 1/4 oz.
Cranberry Juice	Cold	1 1/2 oz.	1 3/4 oz.	2 oz.	2 1/2 oz.
Cranberry Juice	Warm	1 1/2 oz.	1 3/4 oz.	2 1/4 oz.	2 1/2 oz.
Grape Juice	Cold	1 1/2 oz.	2 oz.	2 1/4 oz.	3 oz.
Grape Juice	Warm	1 3/4 oz.	2 oz.	2 1/4 oz.	2 1/2 oz.
Prune Juice	Cold	1 1/4 oz.	1 3/4 oz.	2 1/4 oz.	2 3/4 oz.
Prune Juice	Warm	1 3/4 oz.	2 oz.	2 1/4 oz.	2 3/4 oz.

Consistency Table for Liquids

LIQUID	TEMP	NECTAR	THICKER THAN NECTAR	HONEY	PUDDING
Crystal Light	Cold	1 1/2 oz.	2 oz.	2 1/4 oz.	2 3/4 oz.
Crystal Light	Warm	2 oz.	2 1/4 oz.	2 1/2 oz.	3 oz.
Fruit Punch	Cold	1 oz.	2 oz.	2 1/4 oz.	3 oz.
Fruit Punch	Warm	1 1/2 oz.	1 3/4 oz.	2 1/4 oz.	2 1/2 oz.
Soda Pop	Room	2 oz.	2 1/2 oz.	3 oz.	4 oz.
	Temp.			<i>Note : 12 ounce can of soda used</i>	
Soda Pop	Cold	2 1/4 oz.	3 oz.	3 1/4 oz.	4 oz.
				<i>Note : 12 ounce can of soda used</i>	
Sustacal	Room	1 1/4 oz.	1 3/4 oz.	2 oz.	2 3/4 oz.
	Temp.				
Sustacal	Warm	1 1/2 oz.	1 3/4 oz.	2 oz.	2 1/4 oz.

THICKENED SHAKES

For Cup Drinkers

CARNATION INSTANT BREAKFAST® SHAKE

- 1 cup ice cream
- 1 cup milk
- 1 package Carnation Instant Breakfast®
- 2 Tbs. Karo® syrup, light or dark

Blend well. Makes 15 ounces (450 cc, 1.4 cal/cc, 645 cal.).

RECIPES USING ENSURE®, ENSURE PLUS® OR ENRICH®

- 1 cup Ensure®, Ensure Plus® or Enrich®
- 1 cup ice cream
- 1 cup rice cereal

Blend well. Makes 14 ounces.

Options: Add fruit such as ripe banana or canned peaches.

MILK AND FRUIT SHAKES

Children with Swallowing Difficulties

BANANA MILK SHAKE

- 8 oz. milk
- 1/2 cup baby cereal
- 1 mashed banana

FRUIT MILK SHAKE

- 1/2 cup baby cereal
- 1/2-3/4 cup canned or puréed fruit
(2-3 peach halves,
pear halves)

ORANGE SHAKE

- 1/4 cup orange juice
- 1/2 cup orange sherbet
- 1/4 cup baby rice cereal

APPLE SHAKE

- 1/2 cup apple juice
- 1/2 cup applesauce
- 1/4 cup baby rice cereal

Blend all shake ingredients in a blender, serve cold.

*** Be creative and make your own. Just remember, baby cereal is the thickening agent and should be used in all shakes.

THICKENED SHAKES

For Cup Drinkers

PEACHY SHAKE

- 1 cup milk
- 1 cup diced canned peaches
- 1/2 cup rice cereal

Blend well. Makes two cups (500 cc, .9 cal/cc) (445 cal).

PEARY SHAKE

- 1 jar strained pears (or other fruits)
- 1 cup rice cereal
- 1 cup whole milk

Blend well. Makes 10 ounces (300 cc, 1.35 cal/cc) (390 cal).

SMILEY BANANA SHAKE

- 1 cup milk
- 1 medium ripe banana
- 1 cup vanilla ice cream
- 1 cup baby rice cereal

Blend well. Makes 1 1/2 cups (400 cc, 1.7 cal/cc) (690 cal).

KENNEDY'S HIGH CALORIE FRUIT SHAKE

- 1 jar strained pears
- 1 pkg. vanilla Carnation Instant Breakfast®
- 1 cup rice cereal
- 1 cup vanilla ice cream
- 1 cup whole milk

Blend well. Makes 2 cups (500 cc, 1.6 cal/cc) (780 cal).

THICK ICE CREAM MILK SHAKE

- 1 cup milk
- 1 cup vanilla ice cream
- 1 Tbs. vanilla flavoring
- 1 cup baby rice cereal

Blend well. Makes 1 1/2 cups (400 cc, 1.6 cal/cc) (655 cal).

Calorie Boosters - For Weight Gain

If your child is having trouble gaining weight, listed below are some ways to increase calories.

Powdered Skim Milk: Add 2-4 tablespoons to 1 cup milk. Mix into puddings, potatoes, soups, ground meats, vegetables or cooked cereal.

Carnation Instant Breakfast® (a food supplement): Add to milk or puréed fruit to make milkshakes.

Eggs: Pasteurized egg substitute only. Blend into milkshakes or other beverages. Add to casseroles, hamburger or soups.

Avocado: As a spread or add to any savory dish.

Corn Oil or Margarine: Add to puddings, casseroles, sandwiches, vegetables, soups, cooked cereal.

Cheeses: Give as snacks or in a sandwich. Add to casseroles and potatoes.

Dried Fruits: Serve as snacks or mix into cereals or desserts.

Peanut Butter: Serve on toast, fruit or as peanut butter logs (see recipe).

Ice Cream: Use in milkshakes

Wheat Germ: Add a tablespoon or two to cereal. Mix into cookie batter, casseroles, puddings, etc.

Super Shake

1 cup ice cream
1 cup milk
1 package Carnation
Instant Breakfast®
Blend Well.

Peanut Butter Logs

1 cup nonfat dry milk
1/2 lb peanut butter
1/2 cup honey
1 cup Rice Krispies®
1 cup 100% bran flakes
1/2 cup raisins
Combine all ingredients well.
Flatten mixture in large pan.
Chill overnight, cut into
2" x 1" squares.

Super Pudding

2 cups milk
2 tbsp vegetable oil
1 pkg instant pudding
3/4 cup nonfat dry milk
crystals
Stir milk and oil, add
pudding mix and mix well.
Pour into dishes of 1/2 cup
servings.

NUTRITION IDEAS

Thicken Food

Fruit shakes - banana, pears, apricots, blended with a little milk
Wheat germ
Bran
Powdered milk
Ensure Plus®, Enrich®, Pediasure®, Compleat®
Rice cereal
Cream of wheat
Brewer's yeast (for salty, savory foods)
Mashed potatoes
Blended cottage cheese
Ricotta cheese
TJ's drink recipe (high calorie - recipe at bottom)

Change Texture

Fork - mashed instead of blended
Puddings with graham cracker crumbs dissolved
Custards/tapioca
Refried beans
Ricotta cheese
Tuna - mashed and stirred in

Chewing

Cooked strips of chicken, rare beef, ham
Carrots, green beans, zucchini, potatoes
French fries, raw strips of cheese, banana, jerky
Wrap food in organza or dip rolled organza in juice/broth (If organza is not available, gauze may be substituted).

Harder to Chew Ideas

Orange segments
Cooked pea pods, partially cooked carrot
Apple slices with/without skins
Cheese cubes or sticks

Formula for Underweight Kids Milkshake *(TJ's drink recipe)*

8 oz. cream cheese
1/2 cup sugar
1 tsp. vanilla flavoring
egg substitute - equivalent to one egg
1 banana

Milk, enough to make liquified.

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Prior Notice about Evaluation/Consent for Evaluation

Dear _____

Date _____

Student Name: _____ has been referred for an evaluation.

The Team is proposing the following:

<input type="checkbox"/> To evaluate your child. <input type="checkbox"/> To reevaluate your child.	<input type="checkbox"/> Based on a review of existing information, no additional evaluation data are needed to determine if your child is or continues to be eligible for special education services or to determine your child's educational needs.
Reason:	Reason: If you disagree, you may request an assessment.

This proposal is based on the following evaluation procedures, tests, records or reports:

Other options we considered were:

We decided against these options because:

Any other factors considered by the team:

Sincerely, _____
Name/Title

Phone

Parents of a child with a disability have protection under the procedural safeguards. For a copy of the procedural safeguards or assistance in understanding this information, please contact the person named above.

Consent for Evaluation

We request your consent because:

- ☐ This is an initial evaluation and will be used to determine whether your child is a child with a disability and to determine special education needs.
- ☐ This evaluation will include intelligence or personality testing.
- ☐ This is a reevaluation and will be used to decide your child's continued eligibility and/or education needs. (Except for tests of intelligence and personality, if you do not respond to a request for written consent for a reevaluation, that evaluation may be conducted without your consent.)

We plan to use the following evaluation procedure(s), assessments and/or test(s):

If the evaluation includes release of student educational records requiring parental consent, the "Records Release Form(s)," dated _____, identifies the records to be released and to whom.

-
- ☐ I give my consent for the evaluation or re-evaluation. I understand my consent is voluntary and may be revoked for any evaluation or reevaluation that has not yet been conducted.
 - ☐ I refuse consent for the evaluation.

Signature (Parent/Guardian/Surrogate Parent)

Date (mm/dd/yyyy)

- ☐ For initial evaluations, a copy of the *Notice of Procedural Safeguards* has been given to the parent.

Prior Notice about Evaluation /Consent for Evaluation

This form is used to:

- Provide written notice and document written parent consent (or refusal) for an initial evaluation or reevaluation.
- Provide written notice to the parent that the team determined that no additional evaluation data is necessary to determine that the child continues to be eligible for special education services or to determine the student's special education needs, and to inform the parent that the parent may request an assessment.
- Obtain and document parent consent for an evaluation that will include individual personality or intelligence testing;
- Tell the parent in writing what evaluation procedures, assessments or tests will be used.
- Citations: 20 USC § 1414 and 1415(b); 34 CFR 300.300, 300.302 and 300.503; OAR 581-015-2090, 2095 and 2310.

Directions:

1. Enter the month, day, and year the form is completed.
2. Enter the name of the parent, guardian, or surrogate parent.
3. Enter the child's name.
4. Indicate the intent of the team (to evaluate, reevaluate, or not to complete further testing), and indicate the reason(s) for this action.
5. Describe any screening, evaluation procedures, tests, records and reports used to make this decision.
6. Describe any other options that the team considered prior to this action.
7. Explain why the options were rejected.
8. Describe any other factors relevant to the decision.
9. Sign and date the notice part of the form.
10. In the consent box, check the relevant boxes indicating the type of evaluation planned.
11. List and describe the specific evaluation procedures, assessments or tests the team plans to use, or describe the type of tests to be used (may attach a separate sheet with this information).

12. If the evaluation includes release of records requiring parent consent, attach "Records Release Form(s)" that identifies the records to be released, and to whom. Enter the date of the release form on the consent form as a cross-reference.

13. Ask the parent to check the appropriate box, and sign and date the form.

Note: If the parent signs refusal or refuses to respond in writing at all, document the district's reasonable attempts to get parent consent, such as detailed records of phone calls, correspondence (including emails), meetings, home visits, etc.

a. For an initial evaluation or reevaluation, if the parent refuses consent, the district may not conduct the evaluation.

b. For a reevaluation, if the parent does not respond after the district's reasonable attempts to get consent, the district may conduct the evaluation as long as it does not include intelligence test or test of personality.

14. For initial evaluations, give the parent a copy of the *Notice of Procedural Safeguards* (parent's rights booklet) and check the box that you have done so.

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Education Agency Logo and Information Here

MEDICAL STATEMENT OR HEALTH ASSESSMENT STATEMENT

Child's Name: _____ Child's Birthdate: _____

Return to: _____ Date needed: _____ Fax # _____

This child has been referred to determine special education eligibility. Oregon law requires that a medical statement or health assessment be obtained for some disabilities. **This information is urgently needed** to determine appropriate services for the child and **to comply with federal timelines** for the special education evaluation. Please answer all questions in row(s) with checked boxes **and sign below.**

1. <input type="checkbox"/>	Does child have a vision problem? <input type="checkbox"/> Yes <input type="checkbox"/> No														
	<p>If yes, check each of the following that apply:</p> <p><input type="checkbox"/> Child's residual acuity is 20/70 or less in the better eye with correction.</p> <p><input type="checkbox"/> Child's visual field is restricted to 20 degrees or less in the better eye.</p> <p><input type="checkbox"/> Child has an eye pathology or progressive eye disease that is expected to reduce residual acuity or visual field to one of the criteria listed above.</p> <p><input type="checkbox"/> Assessment results are inconclusive and child demonstrates inadequate use of residual vision.</p> <p>Additional information about the vision problem(s).</p>														
2. <input type="checkbox"/>	Does child have a hearing problem? <input type="checkbox"/> Yes <input type="checkbox"/> No														
	<p>If yes, complete the following:</p> <p><input type="checkbox"/> Child has a sensory-neural hearing loss.</p> <p><input type="checkbox"/> Child has a conductive hearing loss that: <input type="checkbox"/>is <input type="checkbox"/>is not treatable.</p> <p><input type="checkbox"/> The use of amplification: <input type="checkbox"/>is <input type="checkbox"/>is not appropriate.</p> <p>Additional information about the hearing problem(s).</p>														
3. <input type="checkbox"/>	Does child have a voice disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No														
	If yes , additional information about the voice disorder is needed.														
4. <input type="checkbox"/>	Does child have relevant medical issues that contribute to speech/language problem? <input type="checkbox"/> Yes <input type="checkbox"/> No														
	If yes , a description of the medical issue(s) contributing to speech or language problem is needed.														
5. <input type="checkbox"/>	Does child have an impairment that is expected to last more than 60 calendar days? (Mark all that apply):														
	<table><tr><td><input type="checkbox"/> Autism Spectrum Disorder</td><td><input type="checkbox"/>Yes</td><td><input type="checkbox"/>No</td></tr><tr><td><input type="checkbox"/> Health Impairment</td><td><input type="checkbox"/>Yes</td><td><input type="checkbox"/>No</td></tr><tr><td><input type="checkbox"/> Orthopedic Impairment</td><td><input type="checkbox"/>Yes</td><td><input type="checkbox"/>No</td></tr><tr><td><input type="checkbox"/> Motor Impairment</td><td><input type="checkbox"/>Yes</td><td><input type="checkbox"/>No</td></tr><tr><td><input type="checkbox"/> Traumatic Brain Injury caused by an external force</td><td><input type="checkbox"/>Yes</td><td><input type="checkbox"/>No</td></tr></table> <p>If yes, a diagnosis or a description of the impairment(s) identified above is required.</p>	<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Health Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Orthopedic Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Motor Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Traumatic Brain Injury caused by an external force	<input type="checkbox"/> Yes
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No													
<input type="checkbox"/> Health Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No													
<input type="checkbox"/> Orthopedic Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No													
<input type="checkbox"/> Motor Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No													
<input type="checkbox"/> Traumatic Brain Injury caused by an external force	<input type="checkbox"/> Yes	<input type="checkbox"/> No													
6. <input type="checkbox"/>	Has child been diagnosed with other physical, medical, sensory or mental health condition(s) that may affect his/her educational performance? <input type="checkbox"/> Yes <input type="checkbox"/> No														
	If yes , the diagnosis and a description of the diagnosis are required.														

Medical/Health Professional's Signature & Title: _____ Date: _____

Medical/Health Professional's Printed Name & Title: _____

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**MEDICAL CONDITION STATEMENT FOR EARLY INTERVENTION ELIGIBILITY
(BIRTH TO AGE 3)**

Date: _____ Child's Name: _____ Birthdate: _____

The State of Oregon, through the Oregon Department of Education (ODE), provides Early Intervention (EI) services to infants and young children ages birth to three with significant developmental delays. ODE recognizes that disabilities may not be evident in every young child, but without intervention, there is a strong likelihood a child with unrecognized disabilities may become developmentally delayed.

ODE is requesting your assistance in determining eligibility for Oregon EI services for the child named above. Under Oregon law, a physician, physician assistant, or nurse practitioner licensed in by the appropriate State Board can examine a child and make a determination as to whether he or she has a physical or mental condition that is likely to result in a developmental delay.

Please keep in mind that, while many children may benefit from Oregon's EI services, only those in whom significant developmental delays are evident or very likely to develop are eligible.

Thank you for your time and assistance with this matter.

Medical Condition:

Please indicate if this child has a:

- ☐ Vision Impairment
- ☐ Hearing Impairment
- ☐ Orthopedic Impairment

Comments:

Yes	No	This child has a physical or mental condition that is likely to result in a developmental delay.
<input type="checkbox"/>	<input type="checkbox"/>	

Physician/Physician Assistant/Nurse Practitioner

Date

Print Name: _____ Phone: _____

Please return to: _____

MEDICAL CONDITION STATEMENT FOR EARLY INTERVENTION ELIGIBILITY (BIRTH TO AGE 3)

Oregon law requires that a physician, physician assistant, or nurse practitioner, with the appropriate State Board licensure determine whether the child has a physical or mental condition that is likely to result in a developmental delay. For a physician and physician assistant this licensure in Oregon is from the State Board of Medical Examiners. For a nurse practitioner in Oregon this licensure is from the State Board of Nursing. Physicians, physician assistants, and nurse practitioners from other states must have the appropriate requisite licensure for their state. This form is used by the physician, physician assistant, or nurse practitioner to indicate the child's diagnosis for special education purposes.

Directions:

1. Enter the date the top of the form is completed and sent to the physician, physician assistant, or nurse practitioner.
2. Enter the child's full legal name.
3. Enter the child's birth date.
4. Enter your name and address at the bottom of the form ("please return to").
5. Send the form to the physician, physician assistant, or nurse practitioner.
6. The physician, physician assistant, or nurse practitioner completes the rest of the form by indicating the child's diagnosis, whether the child has a vision, hearing, or orthopedic impairment, any comments and whether the child has a physical or mental condition that is likely to result in a developmental delay. The physician, physician assistant, or nurse practitioner signs and dates the form.



Oregon Health & Science University
Hospitals and Clinics
Centro de Rehabilitación y Desarrollo
Infantil (CDRC)
P.O. Box 574
Portland, OR 97207-0574
(503) 494-8095, Fax (503) 494-4447

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Página 1 de 1

Patient Identification

AUTORIZACIÓN PARA EL USO Y DIVULGACIÓN DE INFORMACIÓN MÉDICA CONFIDENCIAL

TODAS LAS SECCIONES DE ESTE DOCUMENTO **DEBEN** SER COMPLETADAS, DE LO CONTRARIO, LA AUTORIZACIÓN NO SERÁ ACEPTADA.

Yo autorizo a: _____
(Nombre de la persona o entidad que proporciona la información)

(Dirección de la persona/entidad)

(Ciudad)

(Estado)

(Código Postal)

para usar y divulgar una copia de la información médica específica descrita a continuación referente a:

(Nombre del paciente)

consiste en: (ver definiciones al reverso) _____ expedientes médicos _____ Rayos X _____ Laboratorio

_____ Sala de Emergencia _____ informes de CDRC _____ Otros, especifique _____

_____ Si se requieren expedientes clínicos, por favor especifique la clínica(s) (vea al reverso la lista de clínicas) _____

para: _____
(Nombre del receptor)

(Dirección del receptor)

(Ciudad)

(Estado)

(Código Postal)

con el propósito de: (Describa cada propósito de la divulgación de información) _____ Cuidado continuo _____ Legal _____ Discapacidad
_____ Entrar a la escuela _____ Otro, especifique _____

Si la información que será divulgada contiene cualquiera de los tipos de registros o informes indicados a continuación, leyes adicionales relacionadas con el uso y la divulgación de información podrían ser aplicables. Entiendo y estoy de acuerdo con que esta información sea divulgada, sólo si escribo **mis iniciales** en el espacio que precede cada tipo de información.

_____ Información acerca del VIH/SIDA

_____ Información acerca de la salud mental

_____ Información de exámenes genéticos

_____ Diagnósticos, tratamiento o información de referencia de drogas/alcohol

No necesita firmar esta autorización. El negarse a firmar esta autorización no afectará desfavorablemente su derecho de recibir servicios de atención médica o reembolsos por dichos servicios. La única circunstancia en la que negarse a firmar significaría que no recibirá servicios de atención médica es cuando estos servicios tienen únicamente el propósito de proporcionar información a otra entidad, en ese caso se requiere la autorización para poder efectuar esa divulgación. Si se rehúsa a firmar esta autorización no afecta negativamente en su inscripción en un plan de salud ni en su elegibilidad para recibir beneficios de salud, a menos que la información autorizada sea necesaria para determinar si usted es elegible para inscribirse en el plan de salud.

En cualquier momento, usted puede revocar por escrito esta autorización. Si usted revoca esta autorización, la información descrita anteriormente no podrá ser usada o divulgada para los fines descritos en esta autorización. Cualquier uso o divulgación ya efectuados con su permiso, no pueden ser rescatados.

Para revocar esta autorización, por favor envíe una declaración por escrito a: Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Pk Rd. Portland, OR 97239-3098, e indique que usted revoca esta autorización.

Entiendo que la información usada o divulgada mediante esta autorización puede estar sujeta que se re-divulgue, y ya no estar protegida bajo las Leyes Federales. Sin embargo, también entiendo que las Leyes Federales o Estatales podrían restringir la re-divulgación de información acerca del VIH/SIDA, salud mental, información de genética e información de diagnósticos, tratamiento o de referencia sobre drogas/alcohol.

He leído esta autorización y la entiendo en su totalidad.

Esta autorización vence a un año de la fecha en que se firmó, a menos que sea revocada, o especificada de otra forma:
(indique la fecha o evento alternativos) _____

Por: _____
(Firma del individuo o su representante) _____ (Fecha)

Descripción de la autoridad del representante: _____

SPANISH VERSION

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ONLINE 8/2004 (Supersedes 5/04)

MR-4665



MR1470



**Oregon Health & Science University
Hospitals and Clinics**
*Centro de Rehabilitación y Desarrollo
Infantil (CDRC)*
P.O. Box 574
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Viene de la página 1

Patient Identification

DEFINICIÓN DE LOS INFORMES:

- Los informes médicos incluyen el Resumen al Dársele de Alta, Historial Clínico y Examen Físico, cualquier procedimiento o operación
- Rayos X incluyen informes de rayos X, Ultrasonidos, Imágenes de Resonancia Magnética e informes de imágenes especiales
- Laboratorio – Todos los resultados de exámenes de laboratorio
- Sala de Emergencia – Informes médicos de la Sala de Emergencia
- Facturación - Información de facturación del hospital y/o clínica
- Inmunización – todos los informes de inmunización
- CDRC - informes de CDRC
- Otros – Especifique el tipo de información

CLÍNICAS PARA PACIENTES EXTERNOS DE OHSU

Psiquiatría para Adultos
Alergias e Inmunología
Anticoagulación
Audiología
Beaverton
Huesos y Minerales
Transplante de Médula Ósea / Leucemia
Cardiología
Instituto de los Ojos Casey
Centro de Salud para Mujeres
Psiquiatría para Niños y Adolescentes
Centro de Rehabilitación y Desarrollo Infantil (CDRC)
Centro de Rehabilitación y Desarrollo Infantil (CDRC)
en Eugene
Dermatología
Dermatología Quirúrgica
Diabetes
Salud Digestiva
Salud de los Empleados
Endocrinología
Salud de los Ejecutivos
Medicina Familiar en la Colina Marquam
Gabriel Park
Gastroenterología
Pediatria General
GI/ Hepatología
Promoción de Salud y Medicina de Deportes
Hematología / Oncología
Enfermedades Infecciosas

Programa de Psiquiatría Intercultural
Medicina Interna
Lípidos
Transplante de Hígado
Internistas de la Colina Marquam
Nefrología e Hipertensión
Neurología
Neurocirugía
Cirugía Oral y Maxilofacial
Oregon City
Ortopedia
Otorrinolaringología
Clínica Integral para el Dolor
Hematología y Oncología Pediátrica
Especialidades Pediátricas
Perinatal
Cirugía Plástica
Pulmonar
Oncológica Radioterápica
Transplante Renal
Reumatología
Richmond
Riverplace
Scappoose
Sellwood
Medicina del Sueño
Cirugía Oncológica
Urología
Cirugía Vascular



Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Page 1 of 1

Patient Identification

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
ALL SECTIONS OF THIS FORM MUST BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: _____
(Name of person / entity/ facility disclosing information)

(Address of person / entity) (City) (State) (Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check here ☐ for a paper copy. This release is regarding:

(Name of individual)
consisting of: (see back side for definitions) _____ Physician reports _____ X-rays _____ Labs _____ ED
_____ Billing _____ Other, specify _____

_____ If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) (see back side for practice/clinic list) _____

to: _____
(Name of recipient)

(Address of recipient) (City) (State) (Zip Code)

for the purpose of: (Describe each purpose of disclosure) _____ Continued Care _____ Legal _____ Disability
_____ School Entry _____ Other, specify _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Genetic testing information
_____ Mental health information _____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) _____

By: _____ Date: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____



Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Continued from page 1

Patient Identification

DEFINITION OF REPORTS:

- Physician reports include Discharge Summary, Discharge instructions, History & Physical exam, any procedures or operations
- X-rays include X-ray reports, Ultra sound, MRI, and special Imaging reports
- Labs – all laboratory test results
- ED – Emergency Department reports by physician
- Billing – Hospital and / or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed

OHSU OUTPATIENT PRACTICES/CLINICS:

Adult Psychiatry
Allergy & Immunology
Anticoagulation
Audiology
Bone & Mineral
Bone Marrow Transplant / Leukemia
Cardiology
Casey Eye Institute
CDRC Eugene
Center for Women's Health
Child and Adolescent Psychiatry
Childhood Development and Rehabilitation
(CDRC)
Comprehensive Pain Center
Dermatology
Dermatology Surgery
Diabetes
Digestive Health
Doernbecher Pediatrics - Westside
Employee Health
Endocrinology
Executive Health
Family Medicine at South Waterfront
Gabriel Park
Gastroenterology
General Pediatrics
General Surgery
GI / Hepatology
Health Promotion and Sports Medicine
Hematology / Oncology

Infectious Disease
Intercultural Psychiatry Program
Internal Medicine
Knight Cancer Center/Community Hematology
Oncology
Lipids
Liver Transplant
Marquam Hill Internists
Nephrology & Hypertension
Neurology
Neurosurgery
Oral & Maxillofacial Surgery
Orthopaedics
Otolaryngology
Pediatric Hematology / Oncology
Pediatric Specialties
Perinatal
Plastic Surgery
Pulmonary
Radiation Oncology
Renal Transplant
Rheumatology
Richmond
Riverplace
Scappoose
Sleep Medicine
Surgical Oncology
Urology
Vascular Surgery

SHRINERS HOSPITALS FOR CHILDREN®
Authorization for Disclosure of Health Information

Patient Name: _____ Medical Record # _____ Date of Birth _____

Address: _____

Telephone _____

For the period(s) of health care from (date) _____ to (date) _____

1. I hereby authorize Shriners Hospitals for Children®, _____ to disclose to:

Name: _____

Street Address: _____

City, State & Zip Code: _____

2. Information to be disclosed:

- | | | |
|---|---|---|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Progress notes | <input type="checkbox"/> Operative reports |
| <input type="checkbox"/> History & physical examination | <input type="checkbox"/> Laboratory tests | <input type="checkbox"/> Consultation reports |
| <input type="checkbox"/> X-ray reports | <input type="checkbox"/> X-ray films/images | <input type="checkbox"/> Photographs/slides |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Other _____ | |

3. Reason for disclosure: _____

4. Separate signature required for release of information related to items below. Initial each line if required.

____ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)

____ Behavioral health services/psychiatric care/psychotherapy records

____ Alcohol and substance abuse diagnosis and treatment records

____ Pregnancy, contraceptives, and sexually transmitted diseases

____ Genetics testing

Signature for release of information in Item 4: _____

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire one year (12 months) from the original date for release of information to family members; six (6) months from the original date for all other releases.**

6. I have had the opportunity to ask questions regarding this Authorization and these questions have been answered fully.

7. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, its successors and assigns, and its agents and employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.

8. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.

☐ I understand that I do not have to and have chosen not to sign this Authorization. My failure or refusal to sign will not affect my child's or my treatment or ability to receive treatment at Shriners Hospitals for Children.

Witnessed by: _____

Signature of Father or Legal Guardian

Signature of Mother or Legal Guardian

Date: _____

Signature of Patient (if 14 years of age or older)

UDA-4



Patient Name & MR #

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Resources in Oregon

Oregon Department of Education

Office of Learning/Student Services Unit
255 Capitol St., NE
Salem, OR 97310-0203
503-947-5600

Oregon Health Sciences Center- Child Development and Rehabilitation Center

CDRC Portland

700 SW Campus Dr.
Portland, OR 97239
503-346-0640
www.ohsu.edu

CDRC Eugene

901 E. 18th Avenue
Eugene, OR 97403
800-637-0700
541-346-3575

Oregon Occupational Therapy Licensing Board

800 NE Oregon Street, Suite 407
Portland, OR 97232-2187
971-673-0198
www.oregon.gov/otlb

Oregon State Board of Examiners for Speech-Language Pathology and Audiology

800 NE Oregon Street, Suite 407
Portland, OR 97232-2187
971-673-0220
www.oregon.gov/bspa

Oregon State Board of Nursing

17938 SW Upper Boones Ferry Rd.
Portland, OR 97224-7012
971-673-0685
www.oregon.gov/OSBN

Oregon Physical Therapist Licensing Board

800 NE Oregon Street, Suite 407
Portland, OR 97232-2187
971-673-0200
www.oregon.gov/PTBrd

Oregon Academy of Nutrition and Dietetics

P.O. Box 46998
Seattle, WA 98146
www.eatrightoregon.org

Regional and Statewide Services for Students with Orthopedic Impairments (RSOI)

Douglas ESD

1871 NE Stephens Street
Roseburg, OR 97470
541-440-4791
www.rsoi.org

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SAMPLE FORMS AND PROTOCOLS

1. Daily Feeding Protocol – Completed Sample
2. Daily Feeding Protocol – Blank
3. Feeding Team Interview and Observation
4. Safe Eating Protocol
5. Referral for Feeding Evaluation
6. Feeding Observation
7. Feeding Evaluation Summary Template
8. Safe Eating Feeding Protocol
9. OT Feeding Assessment
10. SLP Feeding Assessment
11. Nursing Feeding Assessment
12. Daily Feeding Protocol – EI/ECSE
13. No Oral Feeding Handout
14. Daily Feeding Swallowing Protocol
15. Daily Feeding Log
16. Oral Motor Evaluation – Standard
17. Oral Motor Evaluation – Infant and/or Severely Neurologically Involved
18. Safe Feeding Checklist
19. Feeding Training and Monitoring Log
20. Observation of Trained Feeder
21. Nutrition Screening
22. Planning Checklist

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DAILY FEEDING PROTOCOL

Name Sample Student - Jane Doe Teacher Sample Teacher

Date Protocol Developed 11-02-99 Specialist Sample Specialist

Cognition/Attention/Pacing Jane Doe is easily distracted by peers and activity around her in the lunchroom. She needs reminders to slow down and use her protected feeding techniques.

Positioning Encourage use of right hand to hold plate, right elbow resting on table.

Child's Communication Methods Jane Doe augments her spoken language with a combination of limited signs plus gestures. Good receptive language.

Precautions Food cut to bite-sized. Reminders to eat slowly, prevent "stuffing", use good judgement to select safe textures (avoid crunchy textures, ie carrots, taco shells).

Utensils/Equipment Curved spoon with built-up handle, kept in lunchroom kitchen. Uses cut-away cup but drinks directly from milk carton at lunch.

Foods-Dysphagia, Diet I NA II III (see attached list)

Temperature Any

Amount/Spoonful Pre-cut food into safe small bites for Jane Doe to maximize time for eating.

Liquids: Thin OK Thickened What consistency? Drinks milk with lunch, water okay.

Food Likes/Dislikes Personal preference, good judge of what foods she can safely manage.

Food Allergies None identified, eats all foods except hard vegetables ie carrots, celery

Feeding Procedures Jane Doe wears bandanna shirt-protector to lunchroom. Leanna self-selects lunch, lunchroom staff cuts into safe-sized bites as needed and monitors unsafe food

choices. Peer partner opens milk carton at table. Lunchroom assistant gives reminders to eat slowly and use right hand to stabilize plate.

Oral Care and Positioning after Feeding Jane Doe checks with lunchroom assistant before going to recess to be sure she has wiped her face clean. Jane Doe brushes teeth in classroom with class mates.

I have- been trained in the specific feeding needs of this student. I understand this feeding plan can only be modified by the specialist.

Parent - signature

Lunchroom Staff signature

Lunchroom Assistant signature

Lunchroom Staff signature

Lunchroom Assistant signature

JACKSON ESD FEEDING TEAM

Feeding Students in Educational Programs • January, 2002

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DAILY FEEDING PROTOCOL

Name _____ Teacher _____

Date Protocol Developed _____ Specialist _____

Cognition/Attention/Pacing _____

Positioning _____

Child's Communication Methods _____

Precautions _____

Utensils/Equipment _____

Foods—Dysphagia, Diet I _____ II _____ III _____ (see attached list) _____

Temperature _____

Amount/Spoonful _____

Liquids: Thin _____ Thickened _____ What consistency? _____

Food Likes/Dislikes _____

Food Allergies _____

Feeding Procedures _____

Oral Care and Positioning after Feeding _____

I have- been trained in the specific feeding needs of this student. I understand this feeding plan can only be modified by the specialist.

Signatures

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Portland Public Schools
Feeding Team Interview & Observation

Student: _____ Date: _____

Staff Present: _____

Background and Significant History

- Diagnosis: _____
- Regional Eligibility: vision ____ hearing ____ OI ____ ASD ____
- Medication(s): _____
 - Any medications at meal times: _____
- Allergies: If yes, please list: _____
- Pneumonia: If yes, when _____
- Reflux: _____ Fundal plication: _____
- G-Tube: _____ Asthma _____
- Other Surgeries: _____
- Parent Concerns: _____
- Feeding Evaluation: _____
 - If yes, when/where/results: _____
- Swallow Study: _____
 - If yes, when/where? _____
 - Results: _____
 - Release of Information from site? _____
- History of Choking: _____ If yes, Heimlich required? _____

- Dental Care:
 - Brushing teeth tolerated: _____
 - Routine visits: _____
 - Dentist's name: _____
- Dietary/GI:
 - Level of appetite: Good _____ Poor _____
 - # of meals/day _____ Snacks _____
 - Length of time at each meal _____ Snack _____
 - Any coughing/choking/wet or gurgly sounds: Yes/what _____
 - Constipation: _____
 - Weight/height in normal range: _____
 - Food supplements: _____
 - Food Refusals: _____
 - Fussy after meals: _____
- Food Preparation:
 - Independent with food prep: _____
 - Does parent/EA cut food into small bites: _____
 - Blend food: _____
 - Temperature preference: _____
 - Positioning at home during eating: _____
 - Liquids: uses a cup _____ drinks from a straw _____
bottle _____ sippy cup _____
other _____
- Self Feeder
 - With utensils: _____
 - With finger foods: _____
 - Hand dominance: Right _____ Left _____
 - Is cueing needed to encourage eating: _____
- Food Preferences:
 - Likes _____

 - Dislikes _____

Feeding Observation

- Positioning: _____
- Utensils and Equipment Used: _____
- Breath Sounds: Before Food _____ After Food _____
 Before Drink _____ After Drink _____
- Foods Offered and Observations

- Liquids:
 - Natural Consistency _____
 - Thickened Consistency _____ What _____
 - Cup Drinking: _____
 - Straw Drinking: _____
- Oral Motor:
 - Tongue:
 - Midline to Left _____ Midline to Right _____
 - Left to Right _____ Right to Left _____
 - Tongue Thrust:
 - Inside the mouth: _____
 - Outside the mouth: _____
 - Collect bolus: _____
 - Propel bolus: _____
 - Residual Food: _____
 - Chew
 - None: _____ Munch: _____ Vertical: _____ Rotary: _____
 - Cough:
 - Before: _____ During: _____ After: _____ Productive: _____
 - Cough Needed to Clear: _____
 - Speed of Swallow: WNL _____ Delayed _____
 - Number of swallows needed to clear mouth: _____
 - Foul or sour breath: before meal _____ after meal _____

- Head Control: _____
- Facial Tone: _____
- Jaw: _____
- Lips: _____
- Gag Reflex: _____
- Palate: _____
- Voice: _____
- Phonation: _____
- Saliva control without food: _____
- Saliva control with food: _____
- Other: _____
- Communication: verbal _____ nonverbal _____ AC _____ visual system _____
signs _____ gestures _____
- Orientation:
 - Alert and responsive: _____
 - Follows Directions: _____
 - Interested in Eating: _____
 - Cooperative: _____
 - Needed Extra Time: _____
 - Fatigue while eating: _____
 - Sensory Difficulties: _____
 - Snacks Needed: _____

SUMMARY:



PORTLAND PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL EDUCATION

501 N. Dixon / Portland, Oregon 97227
Mailing Address: P.O. Box 3107 / Portland, Oregon 97208-3107
Telephone: (503) 916-3152 Fax: (503) 916-3174

CONFIDENTIAL
DO NOT POST

SAFE EATING PROTOCOL

Do not feed this student if a trained feeder is unavailable; call feeding team member listed on back page or the program secretary at 503-916-3152.

Student:
D.O.B.:

School:
Protocol Date:

All questions regarding this protocol or feeding issues related to this student are to be directed to a member of the Feeding Team.

ALLERGIES: No known allergies related to food.

POSITIONING:

**UTENSILS/
EQUIPMENT:** Staff to wear vinyl gloves during food prep and feeding.

DO NOT FEED:

**CONSISTENCY &
TEXTURE OF
FOOD/FLUIDS:**

CAUTION

**FEEDING
PROCEDURE:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

MEDICATIONS: As per ODE Guidelines, anyone administering medication is required to complete the PPS medication administration training. This includes prescription and non-prescription medication. Medication to be administered in a form consistent with safe eating protocol.

COMMUNICATION:

EMERGENCY Building CPR trained staff to do Heimlich for any choking
PROTOCOL: incident. For any episode of choking or Heimlich, **call 911**,
notify the school building nurse and a member of the feeding team

XX

*Assisting another person with eating creates safety concerns. It is important that school personnel and parents/caregivers recognize the critical nature of the eating process and follow this protocol during all school activities (e.g. school lunch, field trips, outdoor school).

*Only staff who are **trained** by the PPS Feeding Team may assist this student.

***This safe eating protocol may only be modified by the PPS Feeding Team.**

I have received training regarding this protocol and agree to implement it as directed by PPS Feeding Team.

Trained Staff: PLEASE SIGN AND PRINT

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Trained by:

_____ Date: _____

Developed & revised by: Karyn Wilkinson, SLP, (office=503-916-3318, cell=503-307-6405), Tara Kennedy-Barton, OTR, (office=503-916-3319, cell=503-310-4549)
Naoko Koki, OTR, (office= 503-916-3320, cell=971-219-1447).

C: Parent, Staff, School Cum File, Special Education File, and Feeding Team members .

Protocol to be reviewed at least annually by PPS Feeding Team

High Desert Education Service District

REGIONAL SUPPORT SERVICES

520 NW Wall Street • Bend, OR 97701 • 541-693-5700 • FAX 693-5701

REFERRAL FOR A FEEDING EVALUATION

Last Name	First Name	MI	Sex	DOB
-----------	------------	----	-----	-----

School District	School/Preschool	Grade
-----------------	------------------	-------

Teacher(s)	School Phone #
------------	----------------

Parent Name	Home Phone #
-------------	--------------

Address	Work Phone #
---------	--------------

Reason for referral: _____

Has this child been evaluated medically regarding this referral? ☐ Yes ☐ No
(If possible, attach report OR complete the information below.)

Date seen	Physician name/address/phone #
-----------	--------------------------------

Include Names of Team members requesting the referral: _____

Parent Consent for:

_____ Feeding Evaluation

_____ Exchange of Information with school and medical providers.

Parent Signature	Date
------------------	------

Special Education Director's Signature: _____

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High Desert Education Service District REGIONAL SUPPORT SERVICES

520 NW Wall Street • Bend, OR 97701 • 541-693-5700 • FAX 693-5701

FEEDING OBSERVATION

Student: _____ Date: _____

Staff at observation: _____

Food #1: _____

Food #2: _____

Food #3: _____

Food #4: _____

Liquids:

Regular Consistency Y ☐ N ☐

Thickened Consistency Y ☐ N ☐

Cup Drinking Y ☐ N ☐

Straw Drinking Y ☐ N ☐

Food/drink Preference

Likes _____

Dislikes _____

Behavioral observations while feeding/drinking:

Coughing, gagging, choking Y ☐ N ☐

Drooling Y ☐ N ☐

Arches back into hyperextension during/after feeding Y ☐ N ☐

Turns head to left during and after feeding Y ☐ N ☐

Re-swallowing behavior Y ☐ N ☐

Difficulty coordinating breathing/swallowing Y ☐ N ☐

Heimlich or intervention required Y ☐ N ☐

Gurgling during and following swallow Y ☐ N ☐

Tires easily, need small frequent feedings Y ☐ N ☐

Loses liquid/food from mouth Y ☐ N ☐

Poor food lateralization Y ☐ N ☐

Emesis Y ☐ N ☐

Orientation:

Alert and responsive Y ☐ N ☐

Follows directions Y ☐ N ☐

Interested in eating Y ☐ N ☐

Cooperative Y ☐ N ☐

COMMENTS:

Speech Language Pathologist:_____ Phone_____

Occupational Therapist:_____ Phone _____

School Nurse:_____ Phone _____

cc: Parent(s), trained staff, special education file, CORP file, feeding team

High Desert Education Service District REGIONAL SUPPORT SERVICES

520 NW Wall Street • Bend, OR 97701 • 541-693-5700 • FAX 693-5701

FEEDING EVALUATION

Name of Child

Date of Evaluation

Date of Birth

Referral Source and reason for referral:

Physician

The following is a summary of information collected from the individual checklists completed by the OT, SLP, and RN, as well as the feeding observation and risk factor checklists. See attached.

SUMMARY: Student displayed ____ out of ____ risk factors indicating possible swallowing dysfunction.

RECOMMENDATIONS:

Speech Language Pathologist:_____

Occupational Therapist:_____

School Nurse:_____

cc: Parent(s), trained staff, special education file, CORP file, feeding team

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High Desert Education Service District REGIONAL SUPPORT SERVICES

520 NW Wall Street • Bend, OR 97701 • 541-693-5700 • FAX 693-5701

Occupational Therapy Feeding Assessment

Student: _____ Date: _____

Self-feeding skills

Feeds self Y ☐ N ☐ Level of assistance: _____

Uses spoon Y ☐ N ☐ _____

Uses fork Y ☐ N ☐ _____

Uses cup Y ☐ N ☐ _____

Uses bottle Y ☐ N ☐ _____

Finger foods Y ☐ N ☐

Needs frequent cues when mouth is too full Y ☐ N ☐

Needs frequent cues to stay on task Y ☐ N ☐

Needs frequent cues for portion control Y ☐ N ☐

Needs frequent cues for bite size pieces of food Y ☐ N ☐

Needs assistance with set up Y ☐ N ☐

Needs assistance opening containers Y ☐ N ☐

Needs assistance cutting food Y ☐ N ☐

Hand Dominance: Right ☐ Left ☐

Sensory Issues: ☐ Y ☐ N _____

Decreased head/trunk control: ☐ Y ☐ N _____

Abnormal muscle tone: ☐ Y ☐ N _____

Utensils and Equipment Used: _____

Positioning during observation: _____

Comments: _____

Occupational Therapist: _____

This page intentionally left blank

High Desert Education Service District
REGIONAL SUPPORT SERVICES
520 NW Wall Street • Bend, OR 97701 • 541-693-5700 • FAX 693-5701

Speech Language Pathologist Feeding Assessment

Student: _____ Date: _____

Oral Motor

Head Control _____

Facial Tone _____

Jaw _____

Lips _____

Tongue _____

Lateralize L to R Y ☐ N ☐

Lateralize R to L Y ☐ N ☐

Tongue Thrust Y ☐ N ☐

Collect Bolus Y ☐ N ☐

Propel Bolus Y ☐ N ☐

Residual Food Y ☐ N ☐

Cough _____

Clear Throat Y ☐ N ☐

Dentition _____

Gag Reflex _____

Palate _____

Voice _____

Phonation _____

Other _____

Speech Therapist: _____

School: _____ Phone: _____

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**High Desert Education Service District
REGIONAL SUPPORT SERVICES**

520 NW Wall Street • Bend, OR 97701 • 541-693-5700 • FAX 693-5701

Nursing Feeding Assessment

Student: _____ Date: _____

Parent concerns: _____

Medical History

Diagnosis: _____

Medication: _____

Allergies: Y ☐ N ☐ If yes, list _____

Asthma Y ☐ N ☐

Pneumonia Y ☐ N ☐ If yes, list _____

Reflux Y ☐ N ☐

G-Tube Y ☐ N ☐

Feeding evaluation Y ☐ N ☐ If yes, where/when _____

Swallow study Y ☐ N ☐ If yes, where/when _____

History of choking Y ☐ N ☐ If yes, Heimlich required Y ☐ N ☐

Breath Sounds: With stethoscope Y ☐ N ☐

Before Food _____ After Food _____

Before Liquid _____ After Liquid _____

Comments: _____

Nurse: _____

School: _____ Phone: _____

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LBL EI/ECSE Daily Feeding Protocol

Child:		
Teacher:		
Date Developed/By	Date:	By:
Classroom Therapist(s):		
Positioning		
Utensils		
Amount/Spoonful		
Feeding Procedures		
Cognitive/Attention/Pacing		
Position after feeding		
Liquid and/or food consistency		
Precautions		

Date Reviewed with team: _____

Signatures of participants:

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Important Swallowing Instructions

NO ORAL FEEDING

Date: _____ Student: _____

Student, _____, Can not eat/swallow safely. Do not give them anything to eat or drink. This includes all foods and beverages, especially water.

Comments:

Reviewed by:	_____	date	_____
	_____	date	_____
	_____	date	_____
	_____	date	_____
	_____	date	_____

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DAILY FEEDING/SWALLOWING PROTOCOL

Name: --

Date: --

DOB: --

Diagnosis:

Cerebral Palsy, Visual Impairment, Epilepsy

Cognition/Attention/Pacing:

verbal and tactile cueing to aid attention, --
is visually impaired

Positioning:

wheelchair, 90 degree angle

Child's communication Methods:

facial expressions, vocalizations, gestures,
crying, laughing, single button switches

Precautions:

All foods are to be blended or pureed (no
chunks). Make sure mouth is empty before
each bite (palate, cheeks, etc.). Monitor
coughing during food/liquid intake.
Significant coughing should be reported to a
specialist listed below.

Utensils/Equipment:

nosy cup, small spoon (heavy plastic or
metal, no disposable), wet wash cloth

Teacher:

--

Specialists:

--

--

--

Foods-Dysphagia Diet:

pureed consistency

Temperature:

warm or room temperature

Amount/Spoonful:

1 tsp

Liquids:

formula from a bottle or nosy cup

Food Likes/Dislikes:

none known

Food Allergies:

none known

Feeding Procedures:

-- needs direct supervision during feeding. Use gloves at all times. -- can use a spoon to feed himself but sometimes benefits from hand over hand to get most of the food in his mouth. All food needs to be pureed. No chunks. You may need to add water or milk when blending. You can use a thickening agent such as Thick-It if the consistency is too thin. Make sure -- has cleared the food from his mouth between bites. Give -- choices between food items. If he doesn't indicate a food preference guess and tell him what you're offering (e.g., "--, I'm giving you yogurt."). If -- refuses, offer a different choice. Drinking: -- drinks from a bottle at home (not sent to school). He is encouraged to use a nosy cup at school. He does not like to drink from a cup. Do not force him to drink from a cup but offer and encourage him to hold the cup. If he is coughing a lot when drinking alert a specialist listed above as soon as possible.

(refer to back of sheet)

-- Elementary School

Emergency Protocol: A CPR certified staff person needs to be available while -- is eating and drinking at school or during any school activity. In the event of choking call 911 immediately (following school guidelines). Notify the school nurse, administration and --'s parents.

I have been trained in the specific feeding needs for --. I understand this feeding plan can only be modified by the Feeding and Swallowing specialists and I will follow the specifics outlined in this feeding protocol to ensure the safety of -- and myself. If I have questions or concerns regarding this protocol I will contact a specialist listed on this protocol.

The information for this student is confidential and cannot be discussed with anyone other than those designated and directly responsible for the student's care.

This intervention is for the student's needs only and is not transferable to other individuals without specific re-training by a designated Feeding and Swallowing specialist.

This procedure is good for one calendar year from this date, or until change in the student's status necessitates a procedural change. This student will be periodically reassessed for his/her continued need for this intervention.

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

DAILY FEEDING LOG

Student _____ DOB _____ School _____

FEEDING REMINDERS

1. Check Daily Feeding/Swallowing Protocol for setup, precautions prior to feeding.
2. Do not feed the child in isolation. Always have backup in case of emergency.
3. Make sure glasses are on and hearing aids are in place.
4. Keep child in upright position for 20 minutes after feeding.
5. **Contraindications for feeding.** Document and do not feed present meal if the child . . .
 - a. is having a seizure,
 - b. coughs, gags, chokes frequently during feeding,
 - c. has increased congestion or drooling,
 - d. is sleepy or is not alert,
 - e. appears ill or has fever, fatigue, or vomiting,
 - f. attempts many swallows without success,
 - g. has difficulty breathing,
 - h. has unusual skin color, i.e., pale, gray, or bluish tinge,
 - i. cannot be positioned for feeding.

[illegible]

ORAL MOTOR EVALUATION

• Standard •

Name: _____ Date: _____

Evaluator: _____

General postural tone hypertonic _____ hypotonic _____ fluctuating _____

Body alignment at rest _____
during feeding _____

Trunk control at rest _____
during feeding _____

Head control at rest _____
during feeding _____

Saliva reduced _____ excessive _____ within normal limits _____

Oral-facial tone

At Rest:

Cheeks: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

Lips: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

Tongue: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

With Feeding:

Cheeks: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

Lips: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

Tongue: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

Facial characteristics

General appearance: color _____ symmetry _____

Frontal view: Eye spacing: normal _____ hypertelorism _____ other _____

Zygomatic bone: normal _____ hypoplasia _____ other _____

Nasal area: Septum: straight _____ deviated _____

Nares: normal _____ other _____

Columella: normal _____ other _____

Vertical facial dimensions upper: 40% of face _____ other _____

lower: 60% of face _____ other _____

Respiration patterns

Normal: rest _____ activity _____

Abdominal: rest _____ activity _____

Immature abdominal-thoracic: rest _____ activity _____

Asynchronous: rest _____ activity _____

Oral sensitivity

Overall defensive: yes rest _____ activity _____ no _____

Cheeks (right/left; front/back) _____

Tongue (anterior/posterior; right/left) _____

Palate (right/left; alveolar) _____

Lips (top/bottom; right/left) _____

Overload: yes _____ no _____ Describe _____

Occlusion normal _____ overbite _____ underbite _____
 crossbite _____ crowding of teeth _____

Dentition

number of teeth erupted _____

number of adult teeth _____

Caries: not noted _____ 1-2 teeth involved _____ multiple teeth involved _____

Oral reflexes

Rooting: present _____ absent _____

Suck/swallow: present _____ absent _____ ratio of suck/swallow/breath _____

Bite: present _____ absent _____

Gag: not present _____ present reduced _____ present _____
 present hyperreactive _____

Lips

	YES	NO
Spread lips wide on "e"	_____	_____
Round lips for "o"	_____	_____
Rapid alternating "e" & "o" 10 times	_____	_____
Repeat "pah" (15 X 5 seconds)	_____	_____
Tight lip closure (with resistance)	_____	_____
	OPEN	CLOSED
Observe at rest	_____	_____
Observe saliva swallow closure	_____	_____
Lip closure: chewing/swallowing	_____	_____
head posture changes	_____	_____

Jaw

At rest: open _____ closed _____ jut _____ tonic bite _____

In use: stable _____ sliding _____ jut _____

Dissociation: yes _____ no _____ explain _____

Tongue

	YES	NO
Extension & retraction	_____	_____
Touch each corner & move rapidly	_____	_____
Open mouth & touch alveolar ridge (not until 7.5 years old)	_____	_____
Repeat "tah" (15X/5 seconds)	_____	_____
Touch/reach sulci: cheeks	_____	_____
lower alveolus	_____	_____
lip & anterior sulcus	_____	_____
Slide along palatal vault	_____	_____

Palate (soft & hard)

Hard palate: normal _____ vaulted _____ cleft _____ other _____ describe _____

Prolong "ah" (note V/P movement)

Palate retraction _____

Uvula: normal _____ bifid _____ other _____

Fauces

Tonsillar obstruction of isthmus? yes _____ no _____

Tonsil coloration: normal (pinkish) _____ inflamed _____ absent _____

Pharynx

Depth (between velar dimple & pharyngeal wall on "ah") normal _____ deep _____ other _____

Passavant's pad: present _____ absent _____

Adenoids: present _____ absent _____

Summary of findings

Recommendations

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ORAL MOTOR EVALUATION

• Infant and/or Severely Neurologically Involved •

Name: _____ Date: _____

Evaluator: _____

State of arousal–Level of cognitive function

No response–vegetative state _____
Drowsiness (lethargy or obtundation) _____
Stupor (responds to pain) _____
Generalized response _____
Localized response _____
Attention _____
Confused agitated _____
Confused, inappropriate, nonagitated _____
Confused appropriate _____
Automatic appropriate _____
Purposeful appropriate _____
Attention _____

General postural tone hypertonic _____ hypotonic _____ fluctuating _____

Body alignment at rest _____
during feeding _____

Trunk control at rest _____
during feeding _____

Head control at rest _____
during feeding _____

Saliva reduced _____ excessive _____ within normal limits _____

Oral-facial tone

At Rest:

Cheeks: normal _____ hypertonic _____ hypotonic _____ fluctuating _____
Lips: normal _____ hypertonic _____ hypotonic _____ fluctuating _____
Tongue: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

With Feeding:

Cheeks: normal _____ hypertonic _____ hypotonic _____ fluctuating _____
Lips: normal _____ hypertonic _____ hypotonic _____ fluctuating _____
Tongue: normal _____ hypertonic _____ hypotonic _____ fluctuating _____

Facial characteristics

General appearance: color _____ symmetry _____

Frontal view: Eye spacing: normal _____ hypertelorism _____ other _____

Zygomatic bone: normal _____ hypoplasia _____ other _____

Nasal area: Septum: straight _____ deviated _____

Nares: normal _____ other _____

Columella: normal _____ other _____

Vertical facial dimensions

upper: 40% of face _____ other _____

lower: 60% of face _____ other _____

Respiration patterns

Normal: rest _____ activity _____

Abdominal: rest _____ activity _____

Immature abdominal-thoracic: rest _____ activity _____

Asynchronous: rest _____ activity _____

Apnea: yes _____ no _____

length _____ seconds

of incidences/total time of observation _____

Oral sensitivity

Overall defensive: yes _____ no _____

Cheeks (right/left; front/back) _____

Tongue (anterior/posterior; right/left) _____

Palate (right/left; alveolar) _____

Lips (top/bottom; right/left) _____

Overload: yes _____ no _____ Describe _____

Occlusion normal _____ overbite _____ underbite _____

crossbite _____ crowding of teeth _____

Dentition

number of teeth erupted _____

number of adult teeth _____

Caries: not noted _____ 1-2 teeth involved _____ multiple teeth involved _____

Oral reflexes

Rooting: present _____ absent _____

Suck/swallow: present _____ absent _____ ratio of suck/swallow/breath _____

Bite: present _____ absent _____

Gag: not present _____ present reduced _____ present _____

present hyperreactive _____

Lips

		open	closed
Observe at rest		_____	_____
Observe saliva swallow closure		_____	_____
Lip closure:	chewing/swallowing	_____	_____
	head posture changes	_____	_____

Jaw

At rest: open _____ closed _____ jut _____ tonic bite _____

In use: stable _____ sliding _____ jut _____

Dissociation: yes _____ no _____ explain _____

Tongue

Describe movement noted: _____

Palate (soft & hard)

Hard palate: normal _____ vaulted _____ cleft _____ other _____ describe _____

Palate retraction _____

Uvula: normal _____ bifid _____ other _____

Summary of findings

Recommendations

SAFE FEEDING CHECKLIST

Student Name _____ Date _____

Designated Feeder (s) _____

To your knowledge:

YES

NO

1. Has student recently missed school due to illness?

2. Has student recently been hospitalized?

3. Does student appear ill today?
(e.g., fever, excessive fatigue, flu-like symptoms)

Contraindication to safe feeding checklist:

1. Student is sleeping

2. Student is not alert.

3. Student is seizing

4. Student has increased drooling

5. Student had difficulty breathing

6. Student has increased congestion

7. Student coughs, gags, chokes repeatedly

8. Student attempts many times to swallow without success

9. Student has increase in tone

10. Student has unusual skin color, (e.g., ashen, pale, bluish tinge).

11. Student is vomiting

12. Student cannot be properly positioned.

IF ONE OR MORE CONTRAINDICATIONS ARE PRESENT, DO NOT FEED CHILD.
Notify your on-site supervisor.

Do you feel that this child is able to eat this meal safely?

Signature of feeder

Date

Child's Name: _____ Specialist's Name: _____

FEEDING TRAINING AND MONITORING LOG

Initial Training Completed _____	Review I Completed _____	Review II Completed _____
Reviewed General Guidelines for Feeding _____	Guidelines Reviewed _____	Guidelines Reviewed _____
Reviewed Daily Feeding/ Swallowing Protocol _____	Daily Feeding Protocol Reviewed: _____	Daily Feeding Protocol Reviewed: _____
Reviewed Daily Feeding Log _____	No modifications _____ Modifications (see new protocol) _____	No modifications _____ Modifications (see new protocol) _____
Emergency Information Card Completed and in Place _____	Reviewed Daily Feeding Log _____	Reviewed Daily Feeding Log _____
	Reviewed Emergency Information Card _____	Reviewed Emergency Information Card _____
<i>I have participated in and understand the information described above.</i>	<i>I have participated in and understand the information reviewed.</i>	<i>I have participated in and understand the information reviewed.</i>
Primary Feeder _____	Primary Feeder _____	Primary Feeder _____
Backup Feeder _____	Backup Feeder _____	Backup Feeder _____
<i>I have presented the above information to the staff who will be feeding this child.</i>	<i>I have updated and reviewed the above information with the staff who are feeding this child.</i>	<i>I have updated and reviewed the above information with the staff who are feeding this child.</i>
Name _____	Name _____	Name _____
Title _____	Title _____	Title _____

OBSERVATION OF TRAINED FEEDER

Trained Feeder: _____ Date: _____

Student: _____ School: _____

Following Feeding Protocol?	Yes	No	Comments
Feeder avoids allergy producing foods			
Child positioned correctly			
Feeder wears gloves			
Appropriate utensils and equipment used			
Contraindicated foods and fluids avoided			
Consistency/texture appropriate for			
• food			
• fluids			
Feeding procedure followed			
Communication with child appropriate during feeding			
Emergency protocol followed when necessary			

Additional Comments: _____

Feeding Team Member

Clinic/Program: _____ Date: _____

Child's Name: _____

☐ male ☐ female Age: _____ Birthdate: _____

Birth Weight: _____

Was your child born premature (born early) ☐ Yes ☐ No (2 pts if <2 yo and LBW or PM)

If yes, how many weeks was he/she born early _____ weeks

Did you breast feed? ☐ Yes ☐ No If yes, for how long? _____ months

The following questions will help us learn more about your child. Please answer each of the following questions.

1. How does your child appear to you?

☐ overweight (3) ☐ underweight (4) ☐ just right ☐ short(2)

2. Do any of the following apply to your child's food intake? ☐ Yes (4) ☐ No

If yes, check all that apply:

☐ refuses many foods ☐ drinks more than 40 oz milk each day ☐ eats too much

☐ refuses solid foods ☐ eats fewer than 3 times a day ☐ eats too little

☐ has poor appetite ☐ Other _____

3. Does your child have any feeding or eating problems ☐ Yes (4) ☐ No

If yes, check all that apply:

☐ difficulty sucking ☐ Difficulty feeding self ☐ difficulty drinking from cup

☐ difficulty chewing foods ☐ chokes on liquids ☐ Loses food from mouth

☐ using bottle after age two ☐ Chokes on solids ☐ Other _____

4. Does your child have a feeding tube ☐ Yes (5) ☐ No

5. Is your child on a special diet for medical condition ☐ Yes (4) ☐ No

(eg: diabetes, restricted protein). If yes, what kind? _____

6. Is your child allergic to or intolerant of, any foods? ☐ Yes (2) ☐ No

If yes, what foods? _____

7. Does your child regularly have diarrhea? ☐ Yes (3) ☐ No

8. Does your child regularly have constipation? ☐ Yes (2) ☐ No

9. Does your child regularly vomit? ☐ Yes (3) ☐ No

10. In the past six months was your child found to be anemic? ☐ Yes (2) ☐ No

11. Does your child currently have dental problems? ☐ Yes (1) ☐ No

12. Does your child take medications? ☐ Yes (2) ☐ No

If yes, what medication and for how

long? _____

13. Does your child take vitamins/minerals/home remedies? ☐ Yes (1) ☐ No
If yes, name of supplement(s) _____

14. What is your child's activity level?
☐ walks independently ☐ needs help walking (braces/walker) (2)
☐ does not walk ☐ not old enough to walk

15. Do you have trouble buying enough food to feed your family? ☐ Yes (3) ☐ No

16. Does your child participate in any of the following programs? (check all that apply)

☐ CaCoon/Babies First ☐ WIC ☐ Oregon Health Plan
☐ Early Intervention ☐ Food Stamps ☐ Private Insurance
☐ Head Start ☐ Free or Reduced Lunch ☐ SSI
☐ Private Therapy ☐ Other _____

17. Do you have additional concerns about your child's growth, nutrition or eating? ☐ Yes (1) ☐ No

Describe your child's medical diagnosis (check any that apply):

☐ Asthma/pulmonary (lung) Disease ☐ Mental Retardation ☐ HIV/AIDS
☐ Autism/Pervasive Developmental Delay ☐ Cystic Fibrosis ☐ Cancer
☐ Bronchopulmonary Disease (BPD) ☐ Metabolic Disorder (eg: PKU) ☐ Renal (kidney) Disease
☐ Endocrine Disorder (eg: diabetes) ☐ Cerebral Palsy ☐ Cardiac (heart)disease
☐ Orthopedic Problem ☐ Cranifacial (eg: cleft lip/ palate) ☐ High Risk Infant/Child
☐ Chromosome Disorder (eg Down Syndrome) ☐ Spina Bifida ☐ Seizure/epilepsy
☐ Developmental Delay ☐ Gastrointestinal Disorder ☐ Unknown Diagnosis
☐ Sensory Impairment (blind/deaf) ☐ Other: _____

For Office Use Only

Person completing form

☐ Parent or care giver ☐ Teacher ☐ Health Professional ☐ Other _____

Weight _____ Height _____ HC _____ BMI _____
Wt/Age %ile _____ Ht/Age %ile _____ Wt/Ht %ile _____ BMI %ile _____

Risk Rating (0): ☐ No Risk ☐ Low Risk (1-4): Nutrition Information Given ☐ High Risk (5 or more):
Referral

Action Taken:

☐ Referred to nutritionist/feeding clinic ☐ Receiving nutrition services now (where?) _____
☐ Previously seen by Nutritionist ☐ Referred to other services _____

Adapted from USC/UAP Children's Hospital, Los Angeles "A Look at Nutrition", Nutrition Screening form, 9/98

by Child Development and Rehabilitation Center, June 2000. Nutrition Services 503-494-3210

Child Development and Rehabilitation Center

PLANNING CHECKLIST

District Feeding Team Referral Process

1. Feeding Team Members assigned and regular meeting time established:

☐ **Feeding Team Members:**

Speech-Language clinician(s): _____

Occupational Therapist(s): _____

Consulting Nurse(s): _____

Registered Dietician: _____

Special Education/Consulting teacher: _____

Others knowledgeable about feeding and swallowing disorders: _____

☐ **Regular meeting time established:**

Day/Time _____

2. Referral received by Feeding Team: Initial information is shared at the regularly scheduled meeting of the feeding team, the referral is documented and a case manager is assigned:

☐ Method determined for initial referral to team: (ie, name of single point of contact)

☐ Form developed to document date, person referring, student name, concerns, etc.

☐ Criteria established for assigning team member to act as case manager for purposes of specific evaluation: _____

☐ Duties established for case manager, ie:

☐ Sends Permission to Evaluate form for parent signature permitting evaluation to proceed _____

☐ Arranges times/dates for observation and file review _____

3. Permission to Evaluate and Release of Information forms are sent to the child's parent for signature permitting the evaluation to proceed, and for information to be obtained from medical or other sources:

☐ Case manager sends Release of Information form to parent for signature allowing physician to release medical reports to district

☐ Case manager sends signed Release of Information and request for information to doctor to obtain information from medical or other sources

☐ Additional duties determined by team: _____

4. When permission is received, the case manager sets up a time for observation and file review:

☐ Process determined for contacting school to set up observation: _____

5. Observation takes place and anecdotal data is recorded :

☐ Form developed for recording observation data _____

6. Form for documenting feeding concerns is given to teacher and parent:

☐ Form developed for recording information gathered from teacher and parent (via interview form or other method)

☐ Other forms developed as needed: _____

7. Further observation by additional feeding team members takes place, if needed:

☐ Method determined for initiation of observation by additional team members

☐ Forms developed for recording information gathered during oral motor evaluation

8. Further evaluation by medical or other outside resource is recommended, if needed:

☐ Method developed for determining whether further evaluation is needed, e.g. medical evaluation or other information _____

☐ Format developed for contacting parent to request permission to initiate further evaluation _____

☐ Format developed for contacting physician to request medical information

9. Alternative plan developed if the parent or physician refuses to have additional medical evaluation performed, or if the results of the evaluation prohibit the child from being fed orally at school:

☐ Method developed for documenting alternative plan: _____

10. Recommendations are made to the school-based IEP/IFSP Team and a feeding plan is developed:

- ☐ Formats developed for documenting safe and/or remedial feeding program _____

11. Staff is trained and follow-up reviews planned on a schedule decided by Feeding Team:

- ☐ Methods developed for documenting staff training _____

- ☐ Recommended schedule for follow-up training decided by team _____

- ☐ Methods developed for insuring and documenting ongoing monitoring and follow-up training _____