Student Feeding and Swallowing Plan

Date ________________
Review Date ________________
Review Date ________________

Student ______________________ **Teacher** ______________________

Allergies ______________________

Equipment Dish ____________ Utensil ____________
Cup ____________ Straw ____________

Need for help? Independent ____________ Assisted ____________ Dependent ____________
Explain ______________________
____

Food Consistency Pureed ________ Ground ________ Chopped ________ Mashed ________ Bite size ________

Liquids No liquids ______ Thickened liquids ______ (Check consistency)
Nectar Consistency ________ Honey Consistency ________ Pudding Consistency ________

Tube Fed ________

Tube Fed/ Nothing by mouth ________ Tube and Oral Fed ________ Amount fed orally ________

PROCEDURES

Amount of food per bite ______________________

Food placement ______________________

Wait time (allow time for student to swallow multiple times between bites) ______________________

Behavior Techniques ______________________

Phrases used ______________________

Student's Communication or signals during feeding ______________________

____ Keep student in upright position ______ minutes after meal

____ Encourage student to cough to clear throat ____ Offer a drink after ______ bites

Other ______________________

POSITIONING

1. Sitting posture ______________________
2. Chair/seating device ______________________
3. Head position/support ______________________
4. Trunk control/support ______________________
5. Other ______________________

Check here if there is ongoing **Oral Motor Program** ________ (See Therapist/Plan)

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Parent Input — Feeding and Swallowing

Student ______________________ Date of Birth ____________

Current Height and Weight ______________________ Physician ____________

Allergies ____

____

Does your child feed himself/herself?

❑ Yes, independently ❑ Yes, with assistance ❑ No

Does your child enjoy mealtime? ____

____

How do you know when your child is hungry? ____

____

How do you know when your child is full? ____

____

How long does it take your child to complete a meal?

❑ 10–20 min. ❑ 20–30 min. ❑ 30–40 min. ❑ 40–50 min. ❑ >60 min.

Does your child have difficulty with any of the following?

❑ Choking during a meal
❑ Coughing with or without spraying of food
❑ Chewing
❑ Noisy breathing
❑ Gagging
❑ Biting on utensils
❑ Being touched around the mouth
❑ Tongue thrust
❑ Swallowing
❑ Breathing
❑ Gurgly or "wet" voice
❑ Vomiting
❑ Drooling:
__ constant __ frequent __ occasional
❑ Very fussy eating behaviors
❑ Spikes in temperature
❑ Chronic ear infection
❑ Chronic Respiratory problems (pneumonia)

Was or is your child fed through feeding tube?

❑ Yes ❑ No

If yes, then when? ____

Why? ❑ Aspiration ❑ Medication only ❑ Transition to Oral Feeding ❑ Liquids only ❑ Other

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Parent Input — Feeding and Swallowing

What are your child's food preferences?

Likes	Dislikes
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________

What kinds of food does your child eat?

❑ Liquids ❑ Thickened liquids ❑ Pureed ❑ Mashed ❑ Ground
❑ Chopped ❑ Bite-sized pieces ❑ Table foods (whatever your family is eating)

Does your child take any nutritional supplements?

❑ Yes ❑ No If yes, specify ______________

Do certain foods/liquids appear to be more difficult for your child to eat? ______________

____

How is your child positioned during feeding?

❑ Sitting in a chair at a table ❑ Sitting in a wheelchair ❑ Sitting ❑ Held on lap
❑ Reclined ❑ Lying down ❑ Other

What utensils are used?

❑ Bottle ❑ Spoon ❑ Sippy cup ❑ Cup (no lid)
Other adaptive equipment ______________

Has your child ever had a swallow study?

❑ Yes ❑ No If yes, when? ______________

What were the results? ______________

____

Additional Comments or Concerns ______________

____

______________ ______________
Parent Signature Date

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Feeding and Swallowing Evaluation

Student ______________________________ Date ______________

Evaluator(s)/Title(s) ______________________________

Classroom Teacher ______________________________

POSITIONING

	Concerns	Recommendations
Hips		
Trunk		
Head/Neck		
Arms/Hands		
Legs/Feet		

List Seating Equipment Used ______________________________

____

REFLEXES

	Normal	Hyper	Hypo	Absent
Gag reflex	❑	❑	❑	❑
Bite reflex	❑	❑	❑	❑
Rooting	❑ Yes	❑ No		

Comments ______________________________

____

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Feeding and Swallowing Evaluation

TACTILE RESPONSES

	Response to Stimulation	Recommendations
Body		
Face		
Mouth		
Lips		
Tongue		
Teeth		

FOOD CONSISTENCIES ❑ Pureed ❑ Ground ❑ Mashed ❑ Chopped ❑ Bite size
❑ Mixed (Indicate consistencies of mixtures) ____________________

FOOD PREFERENCES List any food preference related to:

Texture ____________________

Taste ____________________

Temperature (i.e. hot/cold/warm) ____________________

Reaction to non-preferred foods ____________________

THERAPEUTIC SPOON FEEDING Spoon Use

Removes food with	❑ suckle	❑ suck	
Waits quietly for spoon	❑ yes	❑ no	
Opens mouth when food is presented	❑ yes	❑ no	
Active participation in removing food	❑ yes	❑ no	
Lips assist	❑ yes	❑ no	
Moves food posteriorly well	❑ yes	❑ no	
Licks lips clean	❑ yes	❑ no	
Position of tongue when spoon is present	❑ thin & cupped	❑ humped	❑ posterior
Amount consumed	__________ in	__________	minutes

Recommendations ____________________

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Feeding and Swallowing Evaluation

ORAL STRUCTURES & MUSCULATURE DURING CHEWING

		Concerns	Recommendations
Jaw	Movement		
	Bite Alignment/Pattern		
Teeth			
Tongue	Elevation		
	Left lateralization – moves from tongue to chewing surface & from side to side		
	Right lateralization – moves from tongue to chewing surface & from side to side		
	Front-to-back Movement – moves food posteriorly		
	Protrusion/Thrust		
Lips			
Palate			

Drooling ☐ yes ☐ no

Comment ______________________________

____

Feeding and Swallowing Evaluation

DRINKING

Liquid Consistencies	❑ Unthickened	❑ Nectar	❑ Honey	❑ Pudding
Moves liquid with	❑ suckle	❑ suck	❑ unable to use cup	
Tongue thrust	❑ yes	❑ no		
Tongue retraction	❑ yes	❑ no		
Anterior loss	❑ none	❑ minimal	❑ excessive	
Appropriate jaw opening	❑ yes	❑ no		
Jaw thrust	❑ yes	❑ no		
Stabilizes cup by	❑ tongue under cup	❑ biting cup	❑ other	
Upper lip closes over cup	❑ yes	❑ no		
Up/down sucking motion	❑ yes	❑ no		
Coordinated breathing with sucking/swallowing	❑ yes	❑ no		

Type of cup needed ________________________________

Response to thickened liquids ________________________________

Recommendations ________________________________

SWALLOWING CONCERNS

❑ pneumonia or history of pneumonia
❑ delayed swallow
❑ multiple swallows
❑ chronic low grade fever
❑ chronic, copious, clear secretions
❑ oral cavity not clear after swallow
❑ larynx does not elevate properly
❑ gagging
❑ coughing
❑ wet voice
❑ congestion
❑ concerns related to weight
❑ tongue pumping

RESPONSE TO FEEDING

❑ alert throughout
❑ facial grimacing
❑ refusal
❑ reflux
❑ lethargic
❑ anxious
❑ vomiting
❑ fatigue
❑ irritable
❑ irregular or audible breathing
❑ increased hypertonicity
❑ facial reddening

Other ________________________________

________________________________ Completed by/Title

________________________________ Completed by/Title

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