FRISCO ISD
School Health Services

FRISCO INDEPENDENT SCHOOL DISTRICT

Parent Report of Feeding and Swallowing Behaviors at Home

Child's Name: _____ Date of Birth: _____

Parent Name:_____ Phone number:_____

Physician: _____ Phone number:_____

Allergies: _____

Does your child feed himself/herself? ____ Yes, independently ____ Yes, with assistance ____ NO
If your child needs assistance, please explain assistance required_____

Does your child enjoy mealtime? _____

How 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 min

Does your child have difficulty with any of the following?
____ Choking during a meal ____ Tongue thrust ____ Very fussy eating behaviors
____ Chewing ____ Breathing ____ Chronic ear infections
____ Noisy breathing ____ Gurgly or "wet" voice ____ Gagging
____ Vomiting ____ Biting on utensils ____ Drooling
____ Coughing with or without spraying of food ____ Chronic respiratory problems (pneumonia)
____ Being touched around the mouth ___ Drooling ___ constant ___ frequent ___ occasional

Was or is your child fed through a feeding tube? ____ Yes ____ No
If yes, when? _____ How often? _____
Why? ____ Aspiration ____ Medication ____ Transition to Oral Feeding ____ Liquids Only ____Other
If your child has a Tube Feeding: **Parents must complete:** ***Request for Medication Administration Form.***
Physician must complete: ***Physician's Authorization-Gastrostomy Form.***

What kinds of food does your child eat orally?
____ Liquids ____ Thickened liquids ____ Pureed ____ Mashed ____ Ground
____ Chopped ____ Bite-sized pieces ____ Table foods (whatever your family is eating)

http://www.asha.org/docs/html/GL2007-00276-F2.html

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? _____
_____

What are your child's food preferences?

Likes	Dislikes
_____	_____
_____	_____
_____	_____

How is your child positioned during feeding?
____ Sitting in a chair ____ Sitting in a wheelchair ____ Sitting ____ Held on lap
____ Reclined ____ Lying down ____ Other

What utensils are used?
____ Bottle ____ Spoon ____ Fork ____ Sippy cup ____ cup (no lid) ____ Straw
____ Other special equipment _____

Has your child ever had a swallow study? ____ Yes _____ No If yes, when? _____
What were the results? _____
_____
Please provide physician report of recent swallow study to the school nurse*

Does your child require a special diet or diet modifications? (i.e. Puree foods, thickener, soft foods only)
_____Yes _____No (my child is safe eating regular table food and liquids)
If YES, what is the diet? _____
Please provide physician orders for prescribed diet modifications to the school nurse*

Additional comments or Concerns _____
_____

Parent Signature _____ Date _____

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