St. Lucie Public Schools

Exceptional Student Education

Feeding Intervention Team (FIT) Screening Referral

Name:_____ **DOB:**_____ **ID#:**_____

School:_____ **Teacher:**_____

Significant Medical Information:

- Current or past tube feeding
- Reported history of feeding or swallowing problems
- Gastroesophageal Reflex Disease (GERD) or frequent vomiting
- Central Nervous System (Cerebral Palsy, genetic syndromes, Traumatic Brain Injury)
- Neuromuscular Disorders (Muscular Dystrophy, other abnormal muscle tone)
- Vocal cord weakness or paralysis
- Cleft palate or other craniofacial anomalies
- Tracheostomy in place
- Weight loss or failure to gain weight
- Other reported diagnosis: _

Observed Behaviors:

- Poor upper body control/posture
- Frequent refusal to eat or drink
- Food and/or drink hypersensitivity/aversion
- Unable to use lips to clear food from utensils or retrieve drink
- Bites utensils or cups
- Food and/or drink escaping from oral cavity
- Food left on tongue, palate, or pocketed in cheeks after swallow
- Swallowing solid without chewing
- Indications of pain during swallow
- Frequent gagging during or after eating
- Coughing or choking during or after eating or drinking
- Watery eyes/tearing during or after eating or drinking

Time of Meal:_____ **Place of Meal:**_____

Teacher Signature: _____ **Date:**_____

ESE Chair Signature: _____ **Date:**_____

FIT Coordinator Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

Parent Email: _____ **Date:**_____

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