Seminar for Feeding Teams

December 7, 2010

Focus on Team Process:

The Salem-Keizer School District Feeding and Swallowing Team

Mark Springer, SLP

Elizabeth Manson, OT

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Jennifer Pennington, PT

Lynn Oehler, RN

FEEDING and SWALLOWING TEAM PROCESS

Referral Source (verbal, e-mail...) ⇉ School RN/Feeding Team Member ⇉ Team discusses and prioritizes evaluation

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Feeding Team RN:
*Contacts parent to obtain history if one does not already exist.
*Sends consent forms (R19, SST1)
*Schedules the evaluation

Annual review of feeding protocol/ guidelines
Student is re-evaluated upon new referral.

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Feeding and Swallowing Team performs evaluation
Recommendations made and feeding protocol developed on-site.

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Feeding Team members train designated staff as necessary. Trained staff sign back page of protocol.

⇈

Feeding Team distributes evaluation report to specific discipline files and health care provider. Clerical staff distributes report to school (case manager).

⇇

Building RN implements safety protocol (aspiration/ choking)

24J Feeding and Swallowing Team Students

STUDENT _____ SCHOOL _____

DOB _____ STUDENT # _____

HC CODES _____ GRADE _____

BUILDING CONTACT _____ AREA OF NEED _____

DATE	REQUEST	ACTION	WHO

Pre-Evaluation Assessment: Feeding and Swallowing

Student's name:_____Student ID#: _____
Date of Birth: _____ Age: _____ Grade: _____
School: _____ Health Care Provider(s) _____
_____
Person providing information: _____
Reason for evaluation_____

BACKGROUND INFORMATION
Pregnancy: _____ normal _____complications _____gestational age at birth
_____
Delivery: _____normal _____complications: _____
_____
Overall development: (gross/ fine motor, language, cognition) _____
_____
_____
History of failure to gain weight/ poor weight gain: ___ no ___ yes
Current Height: _____ Current Weight: _____

MEDICAL HISTORY: Diagnosis: _____
Special diet: __no __yes _____
Medications: __ no __ yes _____
_____
Supplements: __no __yes _____
_____
Allergies: __no __yes _____
Asthma: __no __ yes
Pneumonia/ Respiratory illness (history): __no __yes _____
_____
Surgeries/ Hospitalizations: __no __yes _____
_____
Reflux: __ no __ yes
G-tube: __ no __ history of (when?) _____
__ yes (currently in place) ____Mickey ____Bard ____J-tube
__ fundoplication (eg. Nissen)
Dental care: ___ sees dentist regularly _____ toothbrush used at home regularly
Other dental concerns? _____

Previous feeding evaluation(s): __no __yes (when/ where/ significant findings)
_____
_____
Swallow study: __no __yes (when/ where/ significant findings) _____
_____
_____

FEEDING HISTORY

Onset of feeding problems: Age: _____ Description: _____

_____

_____

Frequent coughing, choking, or gagging during/ after feeding: __no __yes
Abdominal thrusts required: __no __yes
Able to suck: __no __yes
Chews: __no __yes
Swallows: __no __yes
Drooling: __no __yes
Gurgly/ wet vocal quality: __no __yes
Increased breathing rate/ effort noted: __no __yes

Breastfed __ no __ yes: Complications/ tools used _____

_____

Bottle fed __no __ yes: Special formula? _____
Type of nipple(s) _____
Introduction of foods: Age _____ Complications: _____

_____

Food consistency safely tolerated:
Regular diet: ____
Pureed/ Strained (Stage I): ___
Mechanical soft with moisture/ Junior foods (Stage II): ____
Mechanical soft (Stage III): ____

Liquid consistency safely tolerated:
Thin liquids (eg. water): ____
Nectar thick: _____
Honey thick (soft): _____
Pudding thick (firm): _____

Feeders:
Independent:____ Feeds self with support/ monitoring _____ Does not feed self _____
If needed, person who regularly feeds: _____
Other feeders? _____

Utensils/ adaptive equipment (food/ drink)
Finger feeding ____ Standard spoon ____ Standard fork ____
Any modifications? _____
Regular cup _____ Sippy cup _____ Straw _____ Bottle _____
Other: _____

Location for eating/ feeding:

Feeder's lap: ___ High chair: ___ Infant seat: ___

Floor: ___ Stand at table/ roams: ___ Couch/ lounge chair: ___

Booster seat: ___ Regular chair at table: ___ Other: _____

Environment (when eating/ fed)

Eats/ sits with family: ___ TV/videos on: ___

Easily distracted (eg. noise, other children): _____

Specific behaviors/ routines associated with eating: _____

_____

Other: _____

Intake/ Output: (Diet diary sent to family: _____)

Typical meal schedule/ routine: # of meals _____ # of snacks _____

Fluid intake in 24 hours (note oral or G-tube): _____

_____

Toilet trained ___ Diapers/ Pull-Ups ____ # of voids/ wet diapers in 24 hours: _____

Chronic constipation _____ Frequent diarrhea/ loose stools _____

Foods/ liquids child currently and regularly accepts:

Fruits Meats Vegetables Breads/ Cereals

Sweets Dairy Juice Soda Water

Food preferences/ Favorite foods: _____

_____

Foods regularly rejected: _____

_____

Is there a preferred temperature of food/ liquid? _____

OTHER COMMENTS: _____

_____

_____

_____

Signature: _____ Date: _____

DAILY DIET DIARY

For:_____

(Fill in today's date)

STUDENT'S NAME:_____

BIRTHDATE:_____WEIGHT:_____HEIGHT:_____

Please record all food/ liquids/ medications.

Time	Food/ Liquids Offered Indicate: Oral (O) or Tube (T)	Amount Eaten	Medicationss Indicate Name & Dosage

Additional Comments

Child's appetite today was: _____Usual _____ Better than usual _____Poor

Child was ill today?: _____Yes _____No Describe: _____

If child is on formula: What kind?_____

How made/ mixed?_____

DIARO DE DIETA DIARIA

Para:_____

(Escriba la fecha de hoy)

NOMBRE DEL ESTUDIANTE:_____

FECHA DE NACIMIENTO:_____PESO:_____ALTURA:_____

Por favor escriba toda la comida/líquidos/medicamentos.

Hora	**Comida/líquidos ofrecidos Indique: Oral (O) o Tubo (T)**	**Porción Comida**	**Medicamentos Indique: Nombre y Dosis**

Comentarios adicionales

El apetito del/la niño/a hoy fue: Usual_____ Mejor de lo usual_____ Pobre _____

El/La niño/a estuvo enfermo hoy: _____Sí _____No Describa: _____

Si el/la niño/a toma fórmula: ¿De qué tipo?_____

¿Cómo se hace?_____

Salem-Keizer School District 24J
Student Services
P.O. Box 12024
Salem, OR 97309-0024
399-3101

FEEDING & SWALLOWING TEAM CASELOAD
DATA ENTRY SCREEN
2010-2011

St ID

Date Created 10/28/2010
Date Modified 10/28/2010

Name (Last) (First) MI DOB Sex Grade School

IEP Information StuStID

____ IEP ____ OT Therapy ____ School Health
____ Medicaid ____ PT Therapy ____ Speech Therapy from O M A P

RN Med DX RN CaseNurse

☐ 6A HMP ____ RN ICD9 Code from RN CSLD

Date Referred
Referred by
Status ☐ INACTIVE
Reason
Date of Eval Time Eval
Case Mgr School
Lunch Time Lunch Location
ICD9 Code

TEAM MEMBERS:

SLP ☐ Proofed
RN ☐ Proofed
OT ☐ Proofed
PT ☐ Proofed
OTHER ☐ Proofed
☐ Proofed

DESIGNATED FEEDERS: **DATE FEEDER TRAINED:**

☐ Copy of Protocol sent to Health Care Provider

Team Notes:

Salem-Keizer School District 24J
Student Services
P.O. Box 12024
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(503) 399-3101

FEEDING & SWALLOWING TEAM EVALUATION

2010-2011 School Year

Confidential Information

Name (Last) _____ (First) _____ MI ____ DOB ____ Sex ____ Grade ____ Date ____

St ID _____ School _____ Case Manager _____

Lunch time _____ Lunch location _____

Reason for Referral:

Pertinent History:

Initial Baseline Prior to Food Intake:

1) **Respiratory Status (Nurse):**

☐ Clear to Auscultation ☐ Wheezing ☐ Crackles ☐ Rales

2) **Positioning (PT):**

Head Control:

☐ Independent in maintaining head control ☐ Moderate assist to maintain head control ☐ Dependent in maintaining head control
☐ Minimal assist to maintain head control ☐ Maximal assist to maintain head control

General Postural Tone and Alignment (PT):

Trunk:

☐ Hypertonicity of the trunk musculature ☐ Hypotonicity of the trunk musculature ☐ Fluctuating tone of the trunk masculature

Upper Extremity:

☐ Hypertonicity noted in the left upper extremity ☐ Hypotonicity noted in the right upper extremity
☐ Hypertonicity noted in the right upper extremity ☐ Fluctuating tone noted in the left upper extremity
☐ Hypotonicity noted in the left upper extremity ☐ Fluctuating tone noted in the right upper extremity

Lower Extremity:

☐ Hypertonicity noted in the left lower extremity ☐ Hypotonicity noted in the right lower extremity
☐ Hypertonicity noted in the right lower extremity ☐ Fluctuating tone noted in the left lower extremity
☐ Hypotonicity noted in the left lower extremity ☐ Fluctuating tone noted in the right lower extremity

Positioning (PT):

☐ Student eats while sitting in a standard classroom chair ☐ Student eats while sitting on a cafeteria bench
☐ Student eats while sitting in a wheelchair ☐ Student eats while sitting in a reclined position
☐ Student eats while sitting in a power wheelchair ☐ Student eats while sitting in a sidelying position
☐ Student eats while sitting in an adapted chair

3) **Oral Motor Strength, Function and Control (SLP):**

Volitional Control

Automatic Control

Strength

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Confidential Information

Name (Last) (First) MI DOB Sex Grade Date

St ID School Case Manager

Lunch time Lunch location

Movement

Other:

4) Dental Bite and Tooth Development (SLP, OT):

☐ Dental bite and tooth development are within normal limit ☐ Student has underbite
☐ Student has overbite ☐ Student is missing some teeth

5) Oral-Facial Tone and Sensory Response to Touch Stimulation (OT):

Oral Facial Tone

☐ Hypertonicity was observed ☐ Hypotonicity was observed ☐ Fluctuating facial tone was observed

Sensory Response

☐ Normal ☐ Hypersensitive ☐ Hyposensitive ☐ Retention of primitive rooting reflex

Oral Intake

1) Food and Fluid Intake in a 24-hour period (Nurse):

2) Food and Fluid Textures Introduced During this Evaluation (Team):

Meat	☐ Regular ☐ Mechanical soft ☐ Mechanical soft with moisture ☐ Pureed	☐ Tolerated ☐ Not Tolerated
Veg	☐ Raw ☐ Cooked ☐ Pureed	☐ Tolerated ☐ Not Tolerated
Fruit	☐ Raw ☐ Cooked ☐ Pureed	☐ Tolerated ☐ Not Tolerated
Bread	☐ Regular ☐ Moisture added	☐ Tolerated ☐ Not Tolerated
Snack	☐ Chewy ☐ Crunchy ☐ Dissolves easily	☐ Tolerated ☐ Not Tolerated
Other		☐ Tolerated ☐ Not Tolerated

Food Temperature Preference

☐ Room Temperature ☐ Cold ☐ Warm

Fluid Textures:

☐ Milk ☐ Juice ☐ Water	☐ Tolerated ☐ Not Tolerated
☐ Nectar Thick ☐ Honey Thick ☐ Pudding Thick	☐ Tolerated ☐ Not Tolerated
	☐ Tolerated ☐ Not Tolerated

3) Current Feeding Intake Method and Adaptive Equipment (OT):

Feeding Intake Method:

☐ Student feeds self independently ☐ Student is dependent on others for oral intake
☐ Student feeds self with some assistance

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2010-2011 School Year

Confidential Information

Name (Last) (First) MI DOB Sex Grade Date

St ID _____ **School** _____ **Case Manager** _____

Lunch time _____ **Lunch location** _____

Adaptive Equipment currently used during meal time:

Utensils
- ☐ Student feeds self finger foods
- ☐ Student eats with a standard spoon
- ☐ Student eats with a standard fork
- ☐ Student eats with built-up handled spoon
- ☐ Student eats with built-up handled fork
- ☐ Student eats with curved handled spoon
- ☐ Student eats with curved handled fork
- ☐ Student eats with weighted spoon
- ☐ Student eats with weighted fork
- ☐ SEE ADDITIONAL INFORMATION

Plate
- ☐ Student uses a standard cafeteria tray during meals
- ☐ Student uses a standard plate during meals
- ☐ Student uses a scoop bowl during meals
- ☐ Student uses a scoop plate during meals
- ☐ Student uses a plate stabilizer during meals
- ☐ SEE ADDITIONAL INFORMATION

Drinking
- ☐ Student drinks from a standard milk or juice carton
- ☐ Student drinks with a standard cup/glass
- ☐ Student drinks from a straw
- ☐ Student drinks from a restricted flow cup with a spout
- ☐ Student drinks from a nose cut-out cup
- ☐ SEE ADDITIONAL INFORMATION

4) Oral Pharyngeal Control During Oral Intake (SLP):

☐ Mastication ☐ Oral-pharyngeal bolus movement ☐ Pocketing ☐ Residual food at pharynx

5) Ongoing Respiratory Status During Oral Intake (Nurse):

☐ Clear to Auscultation ☐ Wheezing ☐ Crackles ☐ Rales

6) Feeding Behavior:

- ☐ Student was alert during this feeding assessment
- ☐ Student was distractible
- ☐ Student was cooperative
- ☐ Student was uncooperative
- ☐ Student followed directions
- ☐ Student was lethargic
- ☐ Student was hungry
- ☐ Student was irritable
- ☐ Student was combative

Feeding and Swallowing Team Recommendations:

1) Positioning:

- ☐ The student will be positioned in a manual wheelchair during meals.
- ☐ SEE ADDITIONAL INFORMATION
- ☐ The student will be positioned in a power wheelchair during meals.
- ☐ The student will be positioned in an adapted chair during meals.
- ☐ The student will be positioned in a regular classroom chair for meals.
- ☐ The student will be positioned on a cafeteria bench for meals.
- ☐ The student requires external head control

2) Safe Liquid Textures:

- ☐ This student is able to safely drink thin liquids.
- ☐ This student is able to safely drink nectary thick liquids.
- ☐ This student is able to safely drink honey thick liquids.
- ☐ This student is able to safely drink pudding thick liquids.
- ☐ This student is not able to safely drink liquids at school.
- ☐ SEE ADDITIONAL INFORMATION

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2010-2011 School Year

Confidential Information

Name (Last) _____ (First) _____ MI ____ DOB ____ Sex ____ Grade ____ Date ____

St ID _____ School _____ Case Manager _____

Lunch time _____ Lunch location _____

3) Safe Food Textures:

- ☐ This student is able to safely eat regular textured foods.
- ☐ This student is able to safely eat mechanical soft textured foods.
- ☐ This student is able to safely eat pureed textured foods.
- ☐ This student is not able to safely eat orally at school at this time.
- ☐ SEE ADDITIONAL INFORMATION

4) Foods to Avoid:

- ☐ Avoid chewy foods.
- ☐ Avoid hard foods such as hard candy.
- ☐ Avoid popcorn.
- ☐ Avoid crunchy foods that do not disolve readily in the mouth.
- ☐ Avoid raw vegetalbes.
- ☐ Avoid raw fruits.
- ☐ NONE
- ☐ SEE ADDITIONAL INFORMATION

5) Self-Feeding / Feeding Procedures:

- ☐ This student is able to feed him/herself.
- ☐ This student feeds self with the use of adaptive equipment.
- ☐ This student requires extra time to safely eat.
- ☐ This student requires adult assistance to eat.
- ☐ This student requires hand over hand assistance with utensil.
- ☐ Student requires hand over hand assistance with cup.
- ☐ Student requires verbal cueing for safety and management.
- ☐ SEE ADDITIONAL INFORMATION

6) Adaptive Equipment required during meal time:

Utensils:

- ☐ Student feeds self finger foods
- ☐ Student eats with a standard spoon
- ☐ Student eats with a standard fork
- ☐ Student eats with built-up handled spoon
- ☐ Student eats with built-up handled fork
- ☐ Student eats with curved handled spoon
- ☐ Student eats with curved handled fork
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- ☐ Student eats with weighted fork
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Drinking:

- ☐ Student drinks from a standard milk or juice carton
- ☐ Student drinks with a standard cup/glass
- ☐ Student drinks from a straw
- ☐ Student drinks from a restricted flow cup with a spout
- ☐ Student drinks from a nose cut-out cup
- ☐ SEE ADDITIONAL INFORMATION

For other medical concerns, consult Health Management Plan. Please contact any of the Feeding Team Members listed below if you have any questions or concerns at (503) 399-3101.

	Team Member(s)	Proofed	Signature(s)	Date
SLP		☐		
RN		☐		
OT		☐		
PT		☐		
OTHER		☐		

FEEDING/SWALLOWING LEVELS

Referral

Evaluation

Feeding/Swallowing Protocol

Student requires trained adult assistant for oral feeding.
-Student is totally dependent on adult assistant
-Student participates with hands-on adult assistance

1:1 Supervision

2-3 Trained Feeders (includes teacher)

Initial Feeding Team evaluation-
Annual review of protocol with student observation or as needed

Feeding Guidelines

Student requires adult assistance with food preparation and/or visual monitoring while eating
-Student actively "self-feeds"

Staff Orientation
-Review of feeding procedure / food prep.
-Review level of feeding assistance required
-2-3 trained feeders

Initial evaluation by OTs and/or COTAs –referral to Feeding Team if indicated

Annual review of guidelines with student observation or as needed

-Review of student's Health Management Plan–
Safety training for aspiration/ choking - Document incidents

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Student Services
P.O. Box 12024
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399-3101

2010-2011 School Year

FEEDING PROTOCOL
Confidential Information

	(Last)	(First)	MI	DOB	Sex	Grade	School
Name							

St ID _____ Case Manager _____

This student has been evalutated by members of the Salem-Keizer School District Feeding Team.

Date of Evaluation _____ **Date of Feeding Protocol** _____

Please notify any member of the Feeding Team of any change to the student's Feeding Protocol .

THIS FEEDING PROTOCOL IS NO LONGER VALID UPON TRANSFER FROM SALEM-KEIZER SCHOOL DISTRICT 24J

Students with swallowing or self-feeding problems are at high risk for choking-aspiration and require supervision and/or assistance to eat safely. Aspiration is when food or fluids enter directly into the airway and may cause coughing. Aspiration is dangerous and may result in choking and/or life threatening pneumonia.
The following recommendations will be necessary in mininizing the risk of aspiration and maximizing safe oral intake.

DO NOT FEED THIS STUDENT IF A TRAINED FEEDER IS UNAVAILABLE.

Designated Feeders: 1 _____ 2 _____
3 _____ 4 _____

1) Positioning:

_____

_____

_____

2) Safe Liquid Textures:

_____

_____

_____

3) Safe Food Textures:

_____

_____

_____

4) Foods to Avoid:

_____

_____

_____

Distribution: Student Behavior File, HealthFile, Case Manager, Feed Swallow Team Member, Parent
Student Services 07/07

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Student Services
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2010-2011 School Year

FEEDING PROTOCOL
Confidential Information

	(Last)	(First)	MI	DOB	Sex	Grade	School
Name							

St ID _____ Case Manager _____

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Date of Evaluation _____ Date of Feeding Protocol _____

Please notify any member of the Feeding Team of any change to the student's Feeding Protocol .

THIS FEEDING PROTOCOL IS NO LONGER VALID UPON TRANSFER FROM SALEM-KEIZER SCHOOL DISTRICT 24J

5) Self-Feeding / Feeding Procedures:

_____

_____

_____

6) Adaptive Equipment required during meal time:

Utensils:

_____

_____

_____

Plate:

_____

_____

_____

Drinking:

_____

_____

_____

For other medical concerns, consult Health Management Plan.
Please contact any of the Feeding Team Members listed below if you have any questions or concerns at (503) 399-3101.

TeamMember(s)		Signature(s)	Date
SLP	_____	_____	_____
RN	_____	_____	_____
OT	_____	_____	_____
PT	_____	_____	_____
OTHER	_____	_____	_____
	_____	_____	_____

Distribution: Student Behavior File, HealthFile, Case Manager, Feed Swallow Team Member, Parent
Student Services 07/07

DISTRIBUTION OF REPORTS

On completion of the evaluation, a temporary feeding protocol is documented and signed by the Feeding and Swallowing Team members present and left in the classroom.

Student Services clerical staff sends the final copy of the feeding/ swallowing protocol to the student's case manager. The case manager is expected to share the information with parent and other school staff as appropriate, as well as replace the temporary protocol with the final copy. Clerical staff also makes copies of the final evaluation and feeding/ swallowing protocol for the Feeding and Swallowing Team members involved in the student's evaluation. The signed master copy of the evaluation and protocol is then placed in the student's feeding file.

The Feeding and Swallowing Team members place a copy of the evaluation and protocol in the professional disciplines' files (PT, OT, SLP).

The Registered Nurse places a copy in the student's health file, sends a copy to the student's health care provider, and attaches a copy to the student's current HMP and gives them to the building's school health nurse.

Students with health management plans have a red notification card placed in their school cumulative file to identify them as having individualized health plans. A sticker will be attached to the red notification card, on completion of the feeding evaluation, stating that this student has specific feeding guidelines or a feeding/ swallowing protocol in place.

DISTRIBUTION SUMMARY:

CLERICAL STAFF

- Final copy of Feeding/ Swallowing Protocol to student's case manager
- Final copy of Feeding/ swallowing Evaluation and Protocol to each Feeding/ Swallowing Team Member involved in student's evaluation.
- Signed master copy of evaluation and protocol to student's feeding file.

CASE MANAGER

- Replace temporary protocol with final copy received.
- Share the information/ feeding and swallowing protocol with student's parent and other school staff, as appropriate.

FEEDING and SWALLOWING TEAM MEMBERS

- Place final copy of feeding/ swallowing evaluation and protocol in each Professional disciplines' file (PT, OT, SLP)
- Feeding/ Swallowing Team RN:
    1. Places a copy of the Feeding/ Swallowing Protocol in the student's health file
    2. Sends a copy of the evaluation and protocol to the student's Health care provider.
    3. Attaches a copy of the protocol to the student's current HMP and gives them to the building's school health nurse.

SALEM•KEIZER
PUBLIC SCHOOLS

RUTH O. GELBRICH, Director
Student Services
PO Box 12024 • Salem, Oregon 97309-0024
503-399-3101 • FAX 503-375-7812 • TDD: 503-399-5562

Sandy Husk, Superintendent

_____

_____

_____

_____

RE: _____
Student's Name DOB

Dear Health Care Provider:

The Salem-Keizer School District has a Feeding and Swallowing Team comprised of a speech/language pathologist, physical therapist, occupational therapist, and a registered nurse.

Evaluations on students may be requested by a student's family and/or school personnel in order to assess a student's safety in relation to oral feeding while at school. A variety of food textures and liquid consistencies are used during the evaluation. If necessary, the team develops a Feeding and Swallowing Protocol and training is implemented with school staff.

Enclosed is a copy of a Feeding and Swallowing Protocol for the student named above. This is provided for your information because, according to our records, this student receives health care services through your office and the district has permission to share this information with you. If you have any questions, please feel free to contact the Salem-Keizer School District Feeding and Swallowing Team at our Student Services Office at 503-399-3101.

We appreciate the opportunity to collaborate with you.

Sincerely,

Eric Richards, Coordinator
Student Services
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