EATING AND FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

PART A			
Student's Name		Age	
Name of School	Grade Level	Classroom	
Does the child have a disability? If Yes, describe the major life activities affected by the disability. Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.		Yes Yes	No No
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority.		Yes	No
If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service.			
PART B			
List any dietary restrictions or special diet.			
List any allergies or food intolerances to avoid.			
List foods to be substituted.			
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground: Pureed:			
List any special equipment or utensils that are needed.			
Indicate any other comments about the child's eating or feeding patterns.			
Parent's Signature		Date:	
Physician or Medical Authority's Signature		Date:	

Source: KDE National School Lunch Administrator's Manual, page 34-35

INFORMATION CARD

Student's Name	Teacher's Name
Special Diet or Dietary Restrictions	
Food Allergies or Intolerances	
Food Substitutions	
Foods Requiring Texture Modifications: Chopped: Finely Ground: Pureed or Blended:	
Other Diet Modifications:	
Feeding Techniques	
Supplemental Feedings	
Physician or Medical Authority: Name Telephone Fax	
Additional Contact: Name Telephone Fax	Additional Contact: Name Telephone Fax
School Food Service Representative/Person Completing Form: Title Signature	Date:

Source: KDE National School Lunch Administrator's Manual, page 34-35

Medical Statement for Children Requiring Special Meals

Name of Student:	School District:
Birth Date:	Grade:
Parent Name:	School Attended:
Telephone:	Telephone:

For Physician's Use

Identify and describe disability or medical condition, including allergies, that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).

Diet Prescription (check all that apply):

❑ Diabetic (include calorie level, carbohydrate count, and/or attach meal plan): _____

❑ Modified Texture and/or Liquids ❑ Food Allergy (list): _____

❑ Reduced Calorie: _____ ❑ Increased Calorie: _____

❑ Other (describe e.g. PKU, Ketogenic, Tube Feeding): _____

Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary. Describe in detail allergies e.g. milk allergy - does that include pudding, cheese, yogurt, etc.

OMITTED FOODS	SUBSTITUTIONS

Indicate Texture (see attached sheet for additional information)**:**

❑ Regular ❑ Chopped ❑ Ground ❑ Pureed

Indicate thickness of liquids:

❑ Regular ❑ Nectar ❑ Honey ❑ Pudding

❑ **Special Feeding Equipment** _____

Additional comments: _____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature **Telephone Number** **Date**

Signature of Preparer or Other Contact **Telephone Number** **Date**

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian **Date**