FABENS INDEPENDENT SCHOOL DISTRICT
CHILD NUTRITION SERVICES

Eating and Feeding Evaluation: Children with Special Dietary 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.	**Yes**	**No**
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**	**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 of this form 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 of chopped into bite size pieces:

Finely ground:

Mashed:

Pureed or Blended:

List any special equipment or utensils that are needed.

Indicate any other comments about the child's eating for feeding patterns.

Person/s Completing this form **Printed Name/ Title:** **Signature:**	**Date:**
Parent **Printed Name:** **Signature:**	**Date:**
Physician or Medical Authority: **Printed Name:** **Signature:**	**Date:**

Initials and date received: **School Nurse:_____**	**Initial sand date received:** **Cafeteria Manager:_____**	**Initial sand date received:** **Teacher:_____**

FABENS INDEPENDENT SCHOOL DISTRICT
CHILD NUTRITION SERVICES

Information Card: Children with Special Dietary Needs

Student's Name	**Teacher's Name**
Special Diet or Dietary Restrictions	
Food Allergies or Intolerances	
Food Substitutions	
Foods Requiring Texture Modifications: **Chopped:** **Finely Ground:** **Mashed:** **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:**
Child Nutrition Representative/Person Completing Form: **Name/Title:** **Telephone:** **Signature:**	**Date:**
Initial and date received by child nutrition services director: _____	