1101 Carter Street
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Eating and Feeding Evaluation

Part A

Child's Name: ______________________ D.O.B.: ______________

- **Does this child have a disability?** ☐ No ☐ Yes **Diagnosis:** ______________________

  If yes, describe how the child's diet is affected by the disability: ______________________

  Does the **child with disabilities** have special nutritional or feeding needs? ☐ No ☐ Yes

  If yes, complete part B of this form and have it signed by a licensed physician.

- If the child is **not disabled**, does the child have special nutritional or feeding needs? ☐ No ☐ Yes

  If yes complete part B and have it signed by a recognized medical authority.

If the child does not require special meals, the parent can skip part B, sign at the bottom and return the form to nutrition services.

Part B

List any allergies or intolerances:

Identify food that must be restricted from the child's diet. If any are life threatening, indicate and attach documentation.

☐ **Milk, please clarify:**
- ☐ Fluid milk
- ☐ Ice cream
- ☐ Cheese
- ☐ Yogurt
- ☐ All items with milk/ milk derivatives

☐ **Eggs, please clarify:**
- ☐ Whole eggs (ex.:Scrambled,hard-boiled, etc)
- ☐ All foods with egg/ egg derivatives

☐ **Peanuts, please clarify severity:**
- ☐ Ingestion
- ☐ Contact
- ☐ Airborne
- ☐ Anaphylaxis possible

☐ **Tree Nuts:** (ex. Almonds, pecan, walnut etc.)

☐ **Soy** ☐ **Wheat**

☐ **Fish** ☐ **Shellfish**

Other: ______________________

List all foods that may be substituted in place of the restricted food: ______________________

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______

List **under** each texture type the foods that need modification. If all foods need to be prepared in this manner, indicate "ALL."

Cut up or chopped (bite-size): __________ 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/Guardian Signature ______________________________ Date ______

Physician/Medical Authority Signature ______________________ Date ______

Printed Name: ______________________ Phone number: __________

Date Received:	**Date Received:**
Nurse:	SLP:
	Kitchen:
	Teaching Staff: