

SHELBY COUNTY PUBLIC SCHOOLS

EATING AND FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

Part A

Student's Name: _____	DOB: _____	Age: _____
Name of School: _____		
Grade: _____		Classroom: _____
Does the student have a disability? If yes, describe the major life activity affected by the disability. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No		
If the child does not require special meals, the parent can sign at the bottom and return this form to the school food service department.		

Part B

List any dietary restrictions or special diet. (Please be specific with Egg and Milk Allergies and if they are approved as a baked ingredient or should be avoided completely)	
List any allergies or food intolerances to avoid.	
List foods to be substituted.	
<p>List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".</p> <p>Cut up or chopped into bite size pieces:</p> <p>Finely Ground:</p> <p>Pureed:</p>	
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 Medial Authority Signature _____	Date: _____