Eating and Feeding Evaluation: Children With Special Needs

Name _____ Classroom _____
Age_____

Does this child have a disability? NO YES
If yes, describe the major life activities affected by the disability.

_____
_____
_____

Does the child have special nutritional or feeding needs? NO YES
If yes, the reminder of the form must be filled out and signed by a **licensed physician.**

List any dietary restrictions or special diet:

_____
_____

List all food allergies. For each food item, list a food to be substituted.

_____
_____
_____
_____

List any food that needs the following change in texture (please write all if needed)
Cut up or chopped into bite sized 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:

_____
_____
_____
_____

Physician Signature

_____

Date: _____/_____/_____

Parent/ Guardian Signature_____

Date _____ /_____ /_____

SCHOOL USE ONLY
Date received: _____ / _____ / _____ CM _____CRC_____ OF_____