School Year: 2016-2017

Hamilton County School Nutrition Department

423-209-5679 423-209-5672 Fax

Eating and Feeding Evaluation: Student with Special Needs

Part A: To be completed by Parent/Guardian

A1. Student Name:	**A7. Date of Birth** / **A8.** ☐**M** ☐**F**
A2. Name of School:	**A9. Grade Level/Classroom or Homeroom:**
A3. Parent/Guardian Name (please print):	**A10. Home Address, City State, Zip Code (REQUIRED):**
A4. Home Phone: **A5. Work Phone:**	
A6. Email address:	

I request service for my child and I give permission to the School Nutrition Central Office to contact the Doctor or other recognized medical authority listed below on these orders if clarification is needed and to release medical records pertaining to my child's health condition as necessary.

A11. Parent/Guardian's Signature: **A12. Date:**

Part B: To be completed by Physician/Medical Authority ONLY*(See instructions on back of this form). A PARENT CAN'T COMPLETE.

B1. Which of the following conditions does the student have? (REQUIRED)

☐Food Allergy, with Anaphylaxis ☐Diabetes

☐Food Allergy, without Anaphylaxis ☐In-born Error of Metabolism (please specify): _____

☐Food Intolerance ☒Other (please specify):_____

B2. Do any of the conditions above substantially limit any of the following major life activities? (REQUIRED)*

☐Breathing (such as anaphylaxis) ☐Seeing ☐Working ☐Hearing

☐Eating* (ONLY select if substantially **LIMITED**, NOT affected) ☐Walking ☐Speaking ☐Bodily Functions

☐Caring for One's Self (such as diabetes) ☐Learning ☐Performing Manual Tasks ☐None of these

*If checked, you must submit an explanation of how the condition substantially limits eating. ☐Other (please specify): _____

B3. Identify foods that must be restricted from the student's diet. *If any can cause anaphylaxis, indicate and attach lab results.*

Milk, please clarify:
- ☐ Fluid Milk
- ☐ Ice Cream
- ☐ Cheese
- ☐ Yogurt
- ☐ Casein & Whey

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

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

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

☐**Soy** ☐ **Wheat** ☐ **Other, please list:**_____

☐**Fish** ☐ **Shellfish** _____

B4. List foods to be substituted. Can state: Any food other than those listed above. (REQUIRED)

B5. If the student needs texture modifications, please indicate below:

☐Mechanical Soft Solids & Chopped Meats (Dysphagia Level 3) ☐ Fork Mashable Solids & Ground Meats (Dysphagia Level 2)

☐Pureed Solids & Meats (Dysphagia Level 1) ☐ Other (Specify):

B6. Indicate additional comments about eating or feeding patterns, including thickened liquids, special equipment or utensils.

B7. Physician's Printed Name:	**B8. Physician's Phone #:**
B9. Physician or Medical Authority's Signature:	**B10. Date:**

Note: The doctor is to fax this form to 423-209-5672. **No accommodations can be made until received and processed.**

SCHOOL NUTRITION CENTRAL OFFICE USE ONLY

☐IEP ☐Approved, Date:_____

☐504 ☐Approved, with modifications:_____

☐IEP Referral to _____ _____, Date:_____

☐504 Referral to _____ ☐Denied, Date:_____

SEE INSTRUCTIONS ON BACK

This institution is an equal opportunity provider.

Revised 07/28/2016

School Year: 2016-2017

Eating and Feeding Evaluation Form Instructions

Overall Instructions and Information:

- This form may be kept on file by the School Nutrition Program, Exceptional Education, 504 Coordinator and/or School Health. It is meant to be completed only if you wish the **cafeteria** to make special accommodations.
- This form is **required** by the USDA if any special accommodations are to be made. All required sections must be completed or the request will be denied until it is complete. **No accommodations can be made until the form is returned (and reviewed) via the fax below or mail to the Supervisor of Nutritional Services, 2501 Dodds Ave, Chattanooga, TN 37407.**
- **Part A** is to be completed by the parent or legal guardian.
- **Part B** If a student has at least one major life activity which substantially limits them, they meet the qualification for being disabled, according to the law. This determines who can complete **Part B** of this form:
    - The student has a disability OR any of the major life activities under B2 are checked: Part B must be completed by a **licensed physician only**.
    - The student does not have a disability and "None of these" is checked under B2: Part B may be completed by a **recognized medical authority**, which includes a: physician, physician assistant, nurse practitioner, chiropractor, doctor of osteopathy, dentist, or podiatrist.

Part A Instructions:

The parent or guardian should complete Part A, and sign and date the form under A10 and A11.

A1. List the student's legal name (no nicknames please).
A2. List the school the student attends.
A3. List the parent or guardian who wishes to be the main contact regarding the special request.
A4. List the home phone number of the contact parent/guardian.
A5. List the work phone number of the parent/guardian.
A6. List the student's date of birth.
A7. Check "M" if the student is male or "F" for female.
A8. List the student's current grade AND their classroom or homeroom.
A9. List the parent/guardian's home address. Notification of the decision will be mailed to this address.
A10 & A11 REQUIRED: The parent needs to sign and date the form.

Part B Instructions:

The licensed physician or recognized medical authority must complete Part B. *A parent cannot complete section B.*

B1. REQUIRED: Check off any of the conditions the student has.

B2. REQUIRED: Check off any major life activities that these conditions substantially limit. Please note that this is different than "substantially affected". For example, a peanut allergy does not typically substantially limit a child's eating (even though it substantially affects eating); however, it DOES substantially limit a child's breathing if it were consumed. Therefore, the physician should check off "Breathing" and not "Eating".

B3. REQUIRED: Check off all foods that the student can NOT have. Where appropriate, specify the form of the restriction.
B4. REQUIRED**:** If you are requesting that foods be restricted; you MUST list foods to be substituted. You may state that they can have any other food not listed.
B5. List foods that need a texture modification. If a puree is needed, indicate the consistency required.
B6. Indicate other notes about the child's eating pattern or if special equipment is needed.
B7 & B8. REQUIRED: The doctor/medical authority needs to clearly print their name and list a contact phone number.
B9 &B10. REQUIRED: The doctor/medical authority needs to sign and date the form.
The doctor is to fax this form to 423-209-5672. No accommodations can be made until received and processed.