**HENRICO COUNTY SCHOOL NUTRITION SERVICES**

# EATING & FEEDING EVALUATION FOR CHILDREN WITH SPECIAL NEEDS

| PART A | | | |
|---|---|---|---|
| Student's Name: | | Age: | |
| Name of School: | Grade Level: | Teacher: | |
| 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 and have it signed by a physician or nurse practitioner. | | Yes | No |
| If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete PART B and have it signed by a physician or nurse practitioner. | | Yes | No |
| If the child does not require special meals, the parent can sign at the bottom and return the form to the School Nutrition Services office. | | | |

| 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"<br>Cut up or chopped into bite size pieces:<br>Finely ground:<br>Pureed: | | |
| List any special equipment or utensils that are needed. | | |
| Indicate any other comments about the child's eating or feeding patterns (May write on back) | | |
| Parents Name: | Signature: | Date: |
| Address: | | |
| Home Phone: | Work Phone: | Cell Phone: |
| Physican or Nurse Practitioner Name: | Signature: | Date: |
| Office Phone Number: | | |

**PLEASE RETURN TO:**

## SCHOOL NURSE

*School Nurse will contact HCPS Dietitian to accommodate any special food requirements.*