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" Cut up or chopped into bite size 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 (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.