



Building success beyond the classroom

# Student Nutrition Services

## Eating and Feeding Evaluation for Children with Special Needs

### Information Card

<b>Student's Name:</b> _____		<b>Teacher's Name:</b> _____	
<b>Special Diet or Dietary Restrictions:</b>			
<b>Food Allergies or Intolerances:</b>			
<b>Foods Requiring Texture Modifications:</b>			
<b>Chopped:</b>			
<b>Finely Ground:</b>			
<b>Pureed or Blended:</b>			
<b>Other Diet Modifications:</b>			
<b>Feeding Techniques</b>			
<b>Supplemental Feedings</b>			
<b>Physician or Medical Authority:</b>			
Authorized Physician Signature _____			
Telephone Number: _____		Fax Number: _____	
<b>Additional Contact:</b>		<b>Additional Contact:</b>	
Name: _____		Name: _____	
Telephone Number: _____		Telephone Number: _____	
Fax Number: _____		Fax Number: _____	
<b>School Nurse/Person Completing Form:</b>			
Title: _____			
Signature: _____		Date: _____	