EATING & FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

Student's Name:	**Age:**	
Name of School:	**Grade:**	**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 of this form.	**YES**	**NO**
If the child is not disabled, does the child have special nutritional or feeding needs? If yes, complete Part B of this form.	**YES**	**NO**

List any dietary restrictions or special dietary needs.
List any food allergies or intolerances.
List food substitutions.
List any foods that need a change in texture. Please list the food and the subsequent required texture.
Indicate any other comments about the child's eating or feeding patterns.

Parent's Signature:	**Date:**
Physician's Name:	**Date:**
Physician's Signature:	**Date:**