

Child's Name \_\_\_\_\_ School/Grade \_\_\_\_\_

Parent Name \_\_\_\_\_ Contact phone number \_\_\_\_\_ email contact \_\_\_\_\_

1	Does the child listed have a <b>disability</b> ? If yes, describe the major life activities affected they the disability:	YES	NO

Does the child have special nutritional or feeding needs? If yes, complete the remainder of the form. Have it <b>signed by a licensed medical authority.</b>	YES	NO
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2	<b>If the child is not disabled</b> , does the child have special nutritional or feeding needs? If yes, complete the remainder of the form. Have it <b>signed by a licensed medical authority.</b>	YES	NO
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3	<b>List the food item(s) to avoid that causes life threatening or severe food intolerances.</b> Severe food intolerances affect normal daily bodily functions of eating and/or digestion and/or respiration that require medication, special assistance, or accommodations.
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4	<b>List the food items to replace or substitute for the items listed above.</b> Note: This <b>must</b> be completed before any substitutions can be made. Examples: diagnosed peanut butter allergy, list cheese, yogurt, non-peanut based proteins. For diagnosed milk allergy, list water or juice.  Please substitute Water for Milk _____ Please substitute Juice for Milk _____
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5	<b>We do not request any replacement or substitution. We are requesting monitoring only for the problematic food or foods to avoid due to religious preferences.</b>	YES	NO
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6	<b>List foods that need the following change in texture.</b> <b>If all foods need to be prepared in this manner, indicate "ALL".</b> Cut up or chopped into bite size pieces: Finely ground: Pureed:
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7	<b>List any special equipment or utensils needed:</b>
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8	<b>Indicate any other comments about the child's eating or feeding patterns.</b>
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Printed Name of Medical Authority \_\_\_\_\_

Signature of Medical Authority \_\_\_\_\_

Office Name and Address \_\_\_\_\_

Office Phone Number \_\_\_\_\_ Office FAX Number \_\_\_\_\_