

Ysleta Independent School District  
 Child Nutrition Services  
 Eating and Feeding Evaluation Form

Student's Name:	Age:	Teacher:	
Name of School:	Grade Level:	Classroom:	
<b>PART A</b>			
Does the child have a disability? <i>Describe the major activities are affected by the disability.</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the child have special feeding needs? If yes, please explain:			Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the child require special meals? <i>If yes, a licensed physician must complete, sign and date part B. If no, the parent can sign below and return to the school cafeteria.</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>PART B</b>			
<b><i>Please State Childs Diagnosis:</i></b>			
List Special Diet and/or Dietary Restrictions:			
List Food Allergies or Intolerances:			
List food Substitutions:			
Foods Requiring Texture Modifications:			
Chopped:			
Finely Chopped:			
Pureed or Blended:			
Other Diet Modifications, Supplemental Feedings and/or Feeding Techniques:			
List any other comments about the child's eating or feeding patterns.			
Parent Signature:	Date:	Telephone #:	
Physician Signature:	Date:	Telephone #:	Fax #: