Ysleta Independent School District

Child Nutrition Services

Eating and Feeding Evaluation Form

Student's Name:	Age:	Teacher:	
Name of School:		Grade Level:	Classroom:
Does the child have a disability? ***Describe the major activities are affected by the disability.***			Yes □ No □
Does the child have special feeding needs? If yes, please explain:			Yes □ No □
Does the child require special meals? ***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.***			Yes □ No □
Please State Childs Diagnosis:			
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 #:	