

Child Nutrition Program

PART A		
Student's Name		Age
Name of School	Grade Level	Classroom Teacher
Does the Child have a Disability? If Yes, describe the major life activities affected by the disability.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
PART B		
List any dietary restrictions or special diet.		
List any allergies or food intolerances to avoid.		
List foods to be substituted.		
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All".		
Cut up of chopped into bite size pieces:		
Finely ground:		
Pureed or Blended:		
List any special equipment or utensils that are needed.		
If child has severe food allergy, does exposure only (olfactory) trigger reaction?		
Parent's Signature	Date:	
Physician or Medical Authority's Signature:	Date:	

Child Nutrition Program

Student Information Card

(To be filled out by District Dietitian)

Student's Name		Teacher's Name	
Special Diet or Dietary Restrictions			
Food Allergies or Intolerances			
Food Substitutions			
Foods Requiring Texture Modifications: Chopped: Finely Ground: Pureed or Blended:			
Other Diet Modifications:			
Feeding Techniques:			
Supplemental Feedings:			
Physician or Medical Authority: Name: Telephone: Fax:			
Additional Contact: Name: Telephone: Fax:		Additional Contact: Name: Telephone: Fax:	
Food and nutrition Representative/Person Completing Form: Title: Signature:		Date	