

CHILDREN WITH SPECIAL DIETARY NEEDS Form: Requires Food Service to PRE PLATE Meals: (circle one) YES or NO

*YES : Pre-plate means student does not get choices based on physicans orders

* NO: Student is responsible to choose his/her own food items

Upon Completion please fax to

District School Nurse & Food Service Director 270-866-6305 or email

patty.meece@russell.kyschools.us and keith.emerson@russell.kyschools.us

INSERT Current
PHOTO of Student

FOR SCHOOL NUTRITION OFFICE USE ONLY:	
Date School Nurse Received Order From Physician:	DATE:
Date School Food Service Director Received order From Physician	DATE:
Date Registered Dietician Received Order from FSD:	DATE:
Date School Cafeteria Manager Received Planned Menu from Dietician:	DATE:

EATING AND FEEDING EVALUATION:

PART A		
Student's Name	Age	
Name of School	Grade Level	Classroom
Does the child have a disability? <i>If yes, describe the major life activities affected by the disability.</i>	Yes	No
Does the child have special nutritional or feeding needs? <i>If Yes, complete part B of this form and have it signed by a licensed physician.</i>	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 and have it signed by a recognized medical authority.	Yes	No
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 or chopped into bite size pieces:		
Finely ground:		
Pureed:		
List any special equipment or utensils that are needed.		
Indicate any other comments about the child's eating or feeding patterns.		
PARENT'S SIGNATURE:		DATE:
Physician or Medical Authority's PRINT: _____ Signature: _____		DATE: