

Stafford Municipal School District

SPECIAL MEALS REQUEST Eating and Feeding Evaluation

Part A		
Student's Name	Age	
Name of School	Grade Level	Classroom
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a <i>licensed physician</i> .		Yes
		No
Part B		
List any dietary restrictions or special diet.		
List any allergies or food tolerances to avoid.		
List foods to be substituted.		
List any 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:		
Indicate any other comments about the child's eating or feeding patterns.		
Parent's Signature	Phone:	Date:
Licensed Physician's Signature	Phone:	Date:

**Please return this form ASAP to your school's front office*