Rockcastle County Schools Nutrition Eating and Feeding Modifications School Year _____

EATING AND FEEDING EVALUATION FORM: must be completed and signed by a Physician if your student requires a dietary restriction. (i.e. no peanut butter, no strawberries, etc.) OR a food substitute (i.e. allergic to cow's milk – substitute soy milk). This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.) This form is good for one school year. It must also be completed and signed by student's Physician to reverse a previous accommodation (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction" etc.)

Completed form may be mailed to Rockcastle County Schools Health Services PO Box 187 Brodhead, KY 40409 or faxed to 606-758-8514.

PART A			
Name of Student:		**Date of Birth:_____/_____/_____**	
Allergies:			
Name of School:	**Grade:**	**Classroom:**	
Does student have a Disability/Special Need? If Yes, describe the major life activities affected.		☐ **Yes**	☐ **No**
Does student have special nutritional or feeding needs? **If Yes, Part B of this form must be completed and signed by a licensed Physician.**		☐ **Yes**	☐ **No**

IF STUDENT DOES NOT REQUIRE SPECIAL MEALS, PARENT/GUARDIAN CAN SIGN AT THE BOTTOM OF THIS FORM AND RETURN THE FORM TO THE SCHOOL'S FOOD SERVICE.

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 student's eating or feeding patterns:	
Parent/Guardian's Signature: _____	**Date:_____/_____/_____**
Physician's Signature: _____	**Date:_____/_____/_____**

For School Use Only—Copy to be filed in student health file, school nutrition file and exceptional children file if applicable

Reviewed by:_____Date:_____Copy Sent to: [ ] Health Services [ ] School Nutrition [ ] Exceptional Children

Physician diagnosed disability/special need [ ] Has IEP or 504 [ ] Needs IEP or 504 Evaluation

District Health Services Allergy Action Plan [ ] Has IHP [ ] Needs IHP