North Andover Public Schools Food Service Department
Special Dietary Needs: Eating and Feeding Evaluation

The U.S. Department of Agriculture School Meals Programs requires that all questions be answered in order for ANY diet modification or substitution to be made in school meals.

Part A	**Student Information (To be completed by Parent/Guardian)**	
Student's Name	Age	Classroom
Name Of School	Grade	School Year 20__to 20__

Does the child have a disability? (please circle one answer) **YES** **NO**

If YES, major life activities affected by the disability.

□ eating □ care for one's self □ performing manual tasks □ walking □ seeing
□ hearing □ speaking □ breathing □ learning □ other

Does the child have special nutritional or feeding needs? **YES** **NO**

(please circle one answer)

If YES, complete PART B of this form and have it signed by a recognized medical authority.

If the child is NOT disabled, does the child have special nutritional or feeding needs?

(please circle one answer) **YES** **NO**

If YES, complete PART B of this form and have it signed by a recognized medical authority.

Religious Restrictions-Please check all that apply **YES** **NO**

□ No Beef □ No Pork □ Other

Proceed to Parent/Guardian Signature Box (Below)

Part B **Special Dietary Need (To be completed by Physician)**

Diagnosis/Special Dietary Needs: **Severe/LIFE THREATENING food allergies require signature of Licensed Physician.**

Medical Restrictions - Food Allergies OR Food Intolerance-Please checkl that apply al

Lactose Intolerance/Dairy Allergy: □ Avoid all dairy products □ No milk to d rink

Food Allergies: □ Ingestion □ Contact □ Inhalation □ Fish
□ Peanut □ Tree nuts □ Wheat □ Egg □ Soy

□ Other life threatening food allergies (list all) - Omit these foods:

Food(s) to be substituted (acceptable alternatives, must be completed):

Texture Modification - Please check

□ Chopped (bite size) □ Ground □ Blended □ Pureed

Indicate any other comments about the child's eating or feeding patterns.		
Physician or Medical Authority	**Printed Name**	
	Signature	
	Address	
	Phone Number	Date
Parent/Guardian	**Printed Name**	
	Signature	
	Address	
	Phone Number	Date

Return form to: North Andover Public Schools, Nurse's office

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