Eating and Feeding Evaluation: Children with Special Dietary Needs

Child's Name:_____ Child's date of Birth:_____

Child Care Provider/Facility Name:_____

Does the child have a disability? Yes ☐ No ☐

> ***What is a Disability?*** **Physical or mental impairment that substantially limits one or more major life activities (includes eating, breathing, digestive and respiratory functions, etc.). Most physical and mental impairments will constitute a disability, it does not need to be life threatening. Ex. Digestion is impaired by lactose intolerance, whether or not consuming milk causes severe distress.**

Describe impairment and the major life activities affected by the disability.

List how to accommodate the impairment:

List Dietary restrictions:

List recommended foods to be substituted:

Indicate any other comments about the child's eating and feeding patterns:

Physician, Physician Assistant, or Nurse Practitioner (APNP) Signature:_____

Physician, Physician Assistant, or Nurse Practitioner (APNP) Signature:_____

Date:_____