

Hopewell-Loudon Local School District Food Service Department  
 Special Dietary Needs: Eating and Feeding Evaluation  
**INFORMATION SHEET**

This information is kept in the Lunchroom Supervisor's office for easy access to special dietary needs.

Student's Name			Teacher's Name											
Name of School	Grade	Classroom	Age	School Year 20__ to 20__										
<b>Special Diet or Dietary Restrictions:</b>														
<b>Religious Restrictions:</b> ___ No Beef      ___ No Pork      ___ Other														
<b>Food Allergies or Intolerances:</b>														
<b>Food(s) to substituted (acceptable alternatives, must be completed):</b>														
<b>Food Requiring Texture Modifications:</b> ___ Chopped (bite size)      ___ Ground      ___ Blended      ___ Pureed														
<b>Other Diet Modifications:</b>														
<b>Feeding Techniques:</b>														
<b>Supplemental Feedings:</b>														
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;"><b>Physician or Medical Authority:</b></td> <td style="border: none;">Printed Name _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Signature _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Address _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Phone Number _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Date _____</td> </tr> </table>					<b>Physician or Medical Authority:</b>	Printed Name _____		Signature _____		Address _____		Phone Number _____		Date _____
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	Phone Number _____													
	Date _____													
<b>School Child Nutrition Representative or Person completing Form</b> Name _____ Title _____ Signature _____														