

# Nutrition and Feeding Information Sheet for Special-Needs Children

This form can be provided to schools and caregivers if special needs exist for your child.

Date \_\_\_\_\_

Child's name \_\_\_\_\_

1. What family members/caregivers are involved in feeding your child?

\_\_\_\_\_  
\_\_\_\_\_

2. Which textures of foods does your child usually eat? Check all that apply:

- Pureed/strained     Mashed     Ground     Chopped
- Finger foods         Regular table food
- Thickened liquids only (trouble swallowing thin liquids)
- Does not eat by mouth (tube fed)

3. Does your child need help with eating?

- No     A little help     A lot of help     Total help needed

What kind of help? \_\_\_\_\_

4. What eating equipment does your child use? Check all that apply:

- Bottle     Fingers     Straw     Scoop Dish
- Bowl     Plate (\_\_\_regular \_\_\_special)
- Spoon (\_\_\_regular \_\_\_infant \_\_\_special)
- Fork    (\_\_\_regular \_\_\_infant \_\_\_special)
- Cup    (\_\_\_regular \_\_\_special)     NG tube, G-tube, or Button

5. How long does it usually take your child to eat?

- 1/2 hour or less        If more than 1/2 hour, how long? \_\_\_\_\_

6. Is your child allergic to any foods?

- Yes If yes, what? \_\_\_\_\_  
 No

Please give detailed information on what the child cannot eat and suggested substitutions.

Does the child need a medical prescription from doctor?

- Yes If yes, is it on file? \_\_\_\_\_  
 No

7. What food(s) does your child:

Like the most

Dislike the most

8. Is your child on a special diet? A special feeding schedule? Please give detailed information.

9. Does your child refuse to eat certain foods that are:

- Crunchy  Hard  Dry  Mushy  Runny  
 Cold  Too Warm  Bland  Spicy  Other

Please give examples:

10. How is your child's appetite?

- Very good  Good  Fair  Poor  Varies

11. Does your child usually finish a meal?

- Yes  No Is finishing food:  Required  Encouraged  Not an issue

12. What type of chair does your child sit in during meals?

- Infant seat  High chair  Booster seat  Table chair  Special chair  
 No chair used  Other special equipment (specify) \_\_\_\_\_

13. Does your child need specific positioning when eating or drinking?

Yes  No If yes, please explain \_\_\_\_\_

---

14. Does your child have or do any of the following?

	Often	Sometimes	Never
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choking/gagging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drooling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throwing food/utensils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not staying seated at the table for eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking food off others' plate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refusing to try new foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not indicate hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not indicate thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What else should caregivers know about in regards to your child's eating habits, or behaviors?

15. Is there a health care specialist, such as an occupational therapist, speech pathologist, registered dietitian, nurse, or doctor, who works with your child and who can help with questions or training?

Yes  No If yes, please list their contact information below:

Name

Phone

Doctor \_\_\_\_\_

Registered Dietitian \_\_\_\_\_

Therapist \_\_\_\_\_

Other \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_