|  |  |
| --- | --- |
| Community Colleges of Spokane Logo | **Spokane County Head Start /ECEAP/EHS****MENU ADAPTATIONS** |
|  |
| Site/room |       | FSC |       | Primary teacher |       |
| Child’s name |       | Date of birth (mm/dd/yyyy) |       |
| Parent/guardian |       | Phone |       | Cell/work |       |
| Health Care Provider |       | Phone |       |
|  |
| **Cultural/Religious/Vegetarian Request – Check the foods that you do not want your child offered:** |
| [ ]  Beef | [ ]  Eggs | [ ]  Fish | [ ]  Pork | [ ]  Poultry |
| [ ]  Gelatin made from animal products | [ ]  Milk and all products made with milk | [ ]  Other:  |       |
|  |
| **Texture Modification/Chewing or Swallowing Concerns** (May require a signed statement from medical provider including the medical or dietary need, foods to be omitted and foods to substitute) **Check the diet your child needs:** |
| [ ]  **Pureed** such as foods ready to swallow without additional chewing |
| [ ]  **Mechanical Soft** such as moist tender or ground meats, yogurt without seeds, most soft breads and cooked grains, canned, soft cooked vegetables without skins, canned fruit, banana, melons and fruit without skins, membranes or seeds. |
| [ ]  **Soft** such as moist, tender meat, fish or poultry, yogurt without seeds, most soft breads and cooked grains, cold cereal softened in milk, crackers as tolerated, soft cooked vegetables with skins, strongly flavored (broccoli) and lettuce only as tolerated, canned fruit, banana, melons and fruit without skins, membranes or seeds. |
| [ ]  **Temporary** texture modification; please list reason and foods to avoid: |
|       |
| [ ]  Other:  |       |
| [ ]  **Thickened liquids**: |       |
| [ ]  **Nothing by mouth:** |       |
| [ ]  List any special eating utensils or equipment required: |       |
| [ ]  Special feeding techniques or help needed from an adult: |       |
| [ ]  Other:  |       |
| **Medically Prescribed Diets (Requires signed statement from medical provider including the medical or dietary need and the diet prescribed) Please write in specifics on line.** |
| [ ]  Diabetic meal plan: |       |
| [ ]  Calorie and/or fat restriction: |       |
| [ ]  High calorie for weight gain: |       |
| [ ]  Food/beverages to be given outside normal meal times: |       |
| [ ]  Other: |       |
| Parent/guardian signature |       | Date |       |
| **Original in child’s file** | **Upload form into ChildPlus** | **Copy to parent** |
| **For staff use only** | [ ]  Health Specialist notified | [ ]  IHP in place | [ ]  IHP needed |
|  | [ ]  Disability Specialist notified  | [ ]  IFSP/IEP in place needed | [ ]  IFSP/IEP |