PORTLAND PUBLIC SCHOOLS
FEEDING TEAM
Request for Assistance

Date of Request:	Referred by:
Student:	Birthdate:
School:	Teacher/Grade:
Parent/Guardian:	Medical Diagnosis:
PPS ID#:	IEP Date: Re-Evaluation Date:

Self Feeder?	Yes ☐	No ☐
Fed orally by an adult?	Yes ☐	No ☐
G-Tube Feeding?	Yes ☐	No ☐
Any food modifications?	Yes ☐	No ☐

If yes what are they?
Breakfast time: Lunch time: Snack time:
What are your major concerns?

Current IEP Team Members

Case Manager:	Special Ed. Teacher:
Speech/Language Pathologist:	General Ed. Teacher:
Occupational Therapist:	Physical Therapist:
APE Teacher:	School Nurse:
Other/Title:	Other/Title:

SEND THIS COMPLETED FORM WITH A COPY OF PRIOR NOTICE ABOUT EVALUATION/CONSENT FOR EVALUATION FORM & PPS REGISTRATION FORM TO "FEEDING TEAM AT JEFFERSON, ROOM A7-8."

For Feeding Team Use:

Date Received:	Feeding Team Case Manager:
TMPR: Yes No	TMPR #: