

Meals & Hydration

Last updated: _____

For anyone helping at mealtimes. Fill in by hand and update it whenever needs change.

Name of the person I support: _____

Emergency contact & phone: _____

FOOD ALLERGIES AND INTOLERANCES

Food	Allergy or intolerance?	Reaction

For serious allergies: Emergency action plan attached? ☐ Yes ☐ No

Prescribed epinephrine location: _____

DIET ORDERS OR RESTRICTIONS (if prescribed: e.g., texture-modified, thickened liquids, low sodium, diabetes meal plan)

Copy the exact wording from the care plan or clinician's instructions, including the IDDSI level if provided.

Ordered/recommended by: _____

Date: _____

FAVORITE FOODS AND DRINKS

FOODS TO AVOID OR DISLIKES

EATING SUPPORT

Utensils / adaptive tools: _____

Cueing or set-up help: _____

Seating / position: _____

Choking or swallowing concerns: _____

Level of help or supervision needed at meals: _____

USUAL MEAL AND SNACK TIMES

Meal / snack	Usual time	What usually works (foods, place, company, pace)
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
Evening		

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HYDRATION

Hydration goal or fluid limit, if prescribed: _____ Preferred drinks: _____

Tips that help: _____

DAILY FOOD AND DRINK LOG (amount eaten: none / some / most / all)

Date	Meal / snack	What and how much eaten	Drinks	Notes

WARNING SIGNS TO REPORT TO THE CARE TEAM

- Coughing or frequent throat clearing while eating or drinking
- Refusing food or drink, or eating or drinking much less than usual
- Possible signs of dehydration, such as dark urine, dry mouth, or less urine than usual
- Weight change, or clothes fitting differently

Other changes I've noticed: _____

Call 911 for choking or trouble breathing.

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Page 2 of 2