FOOD AT SCHOOL

Practical Support for a Calmer, More Positive School Experience

ARFID Parents Series - Resource 8

School food is not only about what is packed. Environment, time, sensory load, safety and adult responses can all change what a child is able to manage.

This detailed parent and school guide looks at the hidden barriers around eating during the school day. It covers lunch halls, sensory overload, time pressure, storage, food temperature, peer attention, staff prompting, safe foods, snacks, medication, physical symptoms, neurodivergence, school trips and food technology. The aim is to protect nutrition and access to education while helping school and home work from the same understanding of ARFID.

1. School eating is not the same as eating at home

A child who manages a food in the kitchen at home may be unable to manage the same food at school. The food may have changed temperature, texture or smell in the lunchbox; the room may be noisy; eating time may be short; peers may be watching; staff may be prompting; and the child may already be carrying the sensory and emotional load of the school day. This is why “they eat it at home” is not proof that refusal at school is deliberate. Context changes what the nervous system has to manage.

2. Find out what is actually being eaten

A packed lunch returning partly empty gives some information but not the whole story. Food may be swapped, thrown away, left because there was not enough time, avoided because it warmed up, or untouched because the child felt watched. School meals can be even harder to quantify. Agree a discreet, non-shaming way for adults to record what was realistically managed when monitoring is clinically necessary. The purpose is to understand nutritional access, not to turn lunch into surveillance.

3. The lunch hall can overwhelm every sense

Lunch halls combine voices, chairs scraping, cutlery, smells, queues, movement, bright lighting, unpredictable food and social demands. For a sensory-sensitive child, the environment can use up the capacity needed for eating. A quieter space, consistent seat, earlier entry, additional time or reduced exposure to strong smells may make a meaningful difference. Adjustments should be based on the child's actual barriers and reviewed as needs change.

4. Time pressure can make a difficult task impossible

Some children eat slowly because chewing, swallowing, decision-making or sensory processing requires more time. Others spend much of the lunch period regulating before they can begin. If a child has only a short window before being sent outside, the food may remain untouched despite genuine intention to eat. Ask how long the child actually has once seated and whether reasonable additional time can be provided without making them conspicuous.

5. Temperature and storage can destroy a safe food

A crisp food may soften, pasta may become sticky, yoghurt may warm, bread may become damp and smells can transfer between compartments. A parent can pack exactly what works at home and still have it arrive as a different sensory object. Note which foods survive transport well. Suitable insulated containers, cool packs where appropriate, separated compartments and careful packaging can protect predictability.

6. Food touching can matter more at school

Lunchboxes often compress foods together during transport. Juice from fruit can touch bread; crumbs spread; sauces leak. If the child relies on separation for sensory predictability, the entire lunch can become unusable. Compartments or individually wrapped components may be practical accessibility supports. This is not a statement that food must remain separated forever; it is a way of keeping nourishment available while flexibility is developed deliberately.

7. Smell can be unavoidable in shared spaces

A child may tolerate their own lunch but be unable to eat beside hot school meals, fish, sauces or other strong smells. Smell can trigger nausea and disgust before a bite is taken. Seating location, ventilation, timing or an alternative eating space can sometimes help. Staff should understand that a sensory response is not corrected by telling the child that another person's food smells nice.

8. Eating around other children can create shame

Children notice differences. A limited lunch, unusual brand, supplement drink or separated foods can attract questions. The child may avoid eating to prevent comments or may throw food away so nobody sees it. Ask privately whether peers are part of the difficulty. Adults can challenge teasing, protect confidentiality and help the child develop a simple response if they want one, without requiring them to explain their diagnosis.

9. Adult attention can become another barrier

A well-meaning adult sitting beside a child, counting bites, praising every mouthful or repeatedly asking them to try can make eating feel like a public performance. Some children benefit from a neutral prompt; others eat better with less observation. A school plan should specify what kind of support helps this child rather than using generic “encouragement”. If monitoring is required, it should be as discreet as possible.

10. Never use hunger as a school consequence

A child should not be made to remain without an accepted food because staff believe they will eventually eat the school option. Nor should lunch be withheld as a behavioural consequence. When a child's intake is restricted, deliberately increasing hunger can worsen distress and nutritional risk. Any concerns about food refusal should be communicated to parents and the relevant health team rather than managed through punishment or coercion.

11. Safe foods at school are part of access to education

If a reliable food allows the child to obtain enough energy to learn, regulate and remain in school, it is doing important work. Nutritional variety can still be addressed with the clinical team. School lunchtime does not have to carry the entire burden of exposure therapy. Protecting dependable intake during a demanding school day may create more capacity for therapeutic work elsewhere.

12. School staff need to understand ARFID is not ordinary fussiness

Brief staff education can prevent harmful assumptions. ARFID may involve sensory sensitivity, low interest in eating, fear of choking or vomiting, physical discomfort and overlapping mechanisms. It can cause nutritional and psychosocial impairment without the child looking visibly underweight. Staff do not need to become clinicians, but they do need to understand why pressure, punishment and comparison with peers can make things worse.

13. Morning intake and school lunch are connected

A child who cannot manage breakfast may reach school already under-fuelled. Conversely, medication, nausea or anxiety may make morning eating particularly difficult. The whole-day plan should consider breakfast, school snack, lunch and after-school opportunities together. Relying on one lunch period to compensate for a difficult morning can place too much pressure on a child who is already coping with school demands.

14. Snacks can protect the day

Where school policy and the child's plan allow, predictable snack opportunities can reduce dependence on one large meal. A child with weak hunger cues or early fullness may manage smaller amounts more reliably. Dietetic advice can help determine appropriate nutritional priorities. Snacks should not be removed because the child did not eat a different meal unless this is part of an individually agreed clinical plan.

15. Medication timing belongs in the conversation

Some medications can affect appetite or gastrointestinal comfort. If intake changes after medication is started or altered, record the timing and discuss it with the prescriber rather than changing medication independently. School may be able to provide useful observations about when appetite appears strongest or weakest. Medication effects are one part of a wider assessment, not an automatic explanation for all eating difficulty.

16. Constipation, reflux and nausea do not stop at the school gate

A child may avoid eating because they feel bloated, nauseated or uncomfortable, or because they avoid using school toilets and become increasingly constipated. Persistent gastrointestinal symptoms deserve medical attention. School can help by allowing appropriate toilet access, water and communication with home. Physical symptoms should not be dismissed simply because the child also has anxiety or ARFID.

17. Neurodivergent children may be spending capacity on masking

An autistic or ADHD child may use significant energy navigating classroom demands, noise, transitions and social expectations. By lunchtime they may have less capacity for an already difficult eating task. Some children also struggle to shift attention from an activity to eating or fail to notice hunger until late. Predictable routines, transition warnings and a calmer environment can support access without assuming every neurodivergent child needs the same adjustments.

18. School trips need a food plan before the day

Trips change timing, location, storage, smells and access to familiar shops. Do not wait until the morning of the trip to discover that the usual safe food cannot be stored or carried. Agree what the child can take, backup options, who holds food if needed and what staff should do if intake is poor. Participation should not be unnecessarily restricted simply because the child needs different food support.

19. Cooking lessons can require adjustments

Food technology can involve strong smells, touching wet ingredients, mixed textures and pressure to taste. A child may be able to learn cooking skills without completing every sensory step in the same way as peers. Reasonable adjustments might include tools instead of direct hand contact, advance notice of ingredients, alternative roles or an agreed approach to tasting. The educational goal should be separated from forcing food consumption.

20. Celebrations and reward food can create unexpected pressure

Cake days, class treats, seasonal events and food-based rewards can make differences visible. The child may want to participate socially but not eat the food. Schools can plan an accepted alternative or allow participation without consumption. Avoid public comments such as “we found something you can eat” unless the child is comfortable with that attention.

21. FROM MY SIDE OF THE TABLE — LIVED EXPERIENCE

From my side of the table, eating difficulty does not disappear because you walk through a school gate. When food is already complicated, being away from the place where you know the brands, preparation and routines can add another layer of uncertainty. Other people may see a lunchbox. The person eating may be thinking about smell, texture, whether the food has changed, whether somebody will notice, whether their body will react and what they will say if they cannot manage it.

22. FROM MY SIDE OF THE TABLE — BEING WATCHED CHANGES THE EXPERIENCE

In my own experience of ARFID, being observed or having food become a subject of discussion can make the eating experience feel bigger. When somebody is already trying to manage their own sensory and bodily responses, adding the sense that another person is waiting for them to eat can increase pressure. My experience is not every child's experience, but it is one reason I want adults in schools to understand that support does not always mean more attention. Sometimes support is creating enough safety and predictability for the person to eat without feeling that they are performing.

23. FROM MY SIDE OF THE TABLE — BELIEVE THE INFORMATION THE CHILD IS GIVING YOU

A child may tell you that the food tastes different, feels wrong, smells stronger or makes them feel sick even though it looked fine when it left home. I know from my own lived experience that the person eating can notice things that are not obvious to somebody watching. That does not mean every explanation will turn out to have the cause first assumed. It means the experience deserves curiosity. A useful response is: “Something changed for you. Let's work out what it was.”

24. Build a school food profile

Create one page containing current reliable foods, important brands, storage needs, common sensory barriers, helpful prompts, unhelpful language, backup options, physical symptoms to watch for and who should be contacted if intake falls. Keep it practical. Staff need a usable guide, not the child's entire clinical history. Review it when safe foods or needs change.

25. Agree what staff should say

Helpful language might include: “Your food is here when you're ready.” “Would the quieter place help today?” “You don't have to explain it in front of everyone.” Avoid “just one bite”, “everyone else is eating”, “your mum packed it so you need to eat it” or “you'll be hungry later”. Consistent language reduces the chance that each member of staff improvises a different response.

26. Agree when school should contact home

Parents do not need a crisis call after every small variation, but repeated or substantial reduction in intake may matter. Agree thresholds appropriate to the child's clinical situation: for example, a pattern of eating almost nothing, inability to drink, significant distress, vomiting, choking concerns or physical symptoms. The child's medical team should guide risk thresholds where nutritional or physical stability is a concern.

27. Protect the child from becoming the messenger

The child should not have to carry complex instructions between parents, school and clinicians. Adults should communicate directly. Written plans reduce the burden on the child to explain why they need a particular food or environment. This is especially important when the child is already anxious about being seen as different.

28. Use a seven-day school pattern map

Record breakfast, school snack, lunch, after-school intake, relevant medication, physical symptoms, difficult lessons or transitions, sensory conditions and what came home in the lunchbox. Look for patterns rather than judging individual days. Perhaps lunch is consistently harder after PE, a certain dining-hall sitting is noisier, or the child reliably eats after school when given decompression time. Patterns create specific problems that can be addressed.

29. Questions for the school meeting

Ask: Where does the child eat? How long do they actually have? Who sits nearby? What happens if the food is refused? Are staff commenting on quantity? Can food from home be stored safely? Is a quieter space available? Are snacks permitted under an individual plan? What happens on trips and celebration days? How will concerns be communicated? Who is responsible for ensuring agreed adjustments happen consistently?

30. Questions for the clinical team

Ask what nutritional priorities school should protect, whether there are minimum intake or hydration concerns, what symptoms require escalation, whether a supplement or fortified food is part of the plan, and whether exposure work should occur at school or elsewhere. Clarify which accommodations support treatment and which goals should be challenged gradually. School should not be left to invent an eating-disorder treatment plan.

31. What progress at school may look like

Progress might be eating a reliable snack consistently, staying in the lunch space with less distress, asking for a quieter place before becoming overwhelmed, bringing home less untouched food, drinking more reliably, participating in a trip with a backup plan or telling staff when a food has become unmanageable. New foods may come later. Reliable nourishment and reduced fear are meaningful outcomes too.

32. Message to parents and schools

The goal is not to make the child eat like everybody else by tomorrow. The goal is to keep them nourished, included and able to learn while the reasons eating is difficult are properly understood and treated. Small adjustments can make a large difference because they remove barriers the child is currently spending enormous energy trying to overcome. School and home work best when neither blames the other and both listen carefully to what the child is showing them.

Evidence and further reading

ARFID can involve sensory sensitivity, low interest in eating and fear of aversive consequences, often in overlapping combinations. Clinical literature recognises both nutritional consequences and psychosocial interference, including difficulty participating in education and social eating. Caregiver-informed and multidisciplinary approaches emphasise the importance of understanding context and reducing barriers while protecting adequate intake. Individual school adjustments should be developed with the child, family, school and relevant health professionals rather than applied as a single standard package.