DIET ORDER FORM For Special Nutritional Needs
Annual Medical statement for Students

PART ONE: (To be filled out completely by parent or guardian)
Student's full name (printed):
Last:_____First:_____Middle:_____

Date of Birth:_____ Age:_____ Student ID#_____

School:_____ Grade:_____ School Year: 20_____to 20_____

Parent/Guardian Name (printed):_____

Daytime phone: _____ E-mail:_____

Mailing Address: _____ City:_____ State: _____ Zip:_____

Does the child have an identified disability? _____ Yes _____ No, my child and I are responsible for self-monitoring his/her food allergy

If yes, please describe the major life activities affected by the disability:_____

Parent/Guardian Signature:_____Date_____

If the student has a disability, PART II MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN

REQUIRED

The child's food allergy that constitutes a disability:_____
_____

An explanation of why the disability restricts the child's diet:_____
_____

The major life activity affected by the disability:_____
_____

The food(s) to be omitted from the child's diet:_____
_____

The food or choice of foods that must be substituted:_____
_____

Indicate which dietary modification the student needs and specify what changes need to be made:
Lactose intolerance / dairy allergy: ☐No milk to drink ☐Avoid all dairy products ☐Water in place of milk

Life threatening food allergies: check appropriate box(es) ☐ ingestion ☐contact ☐inhalation

☐Wheat ☐Soy ☐Eggs (indicate ☐whole eggs or ☐eggs as an ingredient) ☐Fish ☐Shellfish

☐Nuts (indicate ☐peanuts or ☐tree nuts) Others:_____

Texture Modification: ☐pureed ☐ground ☐chopped

MD Name:_____

MD Signature:_____

Phone:_____Fax:_____

Date:_____

Medical Office Stamp:

RETURN THE COMPLETED FORM TO THE SCHOOL'S NURSE – PLEASE ATTACH PHYSICIAN DIET ORDER WITH THIS FORM

For School Use Only: Request Approved_____Request Denied_____Parent Notified_____School Notified_____
Date_____Signature_____