

**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

R E Q U I R E D	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 _____

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