FOOD SERVICE DIET ORDER

for Special Nutritional needs ***Annual*** Medical Statement for Students

Part I (to be filled out annually and completely by parent or guardian) Date:______________________

Parent/Guardian: Complete Items 1 - 6 (Pader/tutor: Compleata cajitas 1-6)			
1) Student's Last Name*(Apellido)*	**First Name** *(Nombre del estudiante)*	**3) Date of Birth** *(Fecha de nacimiento)* **Age** _____	**4) Circle Meals Eaten at School** *(Circule las comidas que su nino/a come en la escuela)* **Breakfast Lunch Snack** (Desayuno) (Amuerzo) (Bocadillo)
5) Parent/Guardian Signature*(Firma del Padres/Tutor)*	**6) Print Name of Parent/Guardian** *(Escriba en letra de molde el nobre del padre/Tutor)*	**7) Parent Phone Number(s)***(Numero(s) de telefono del padres* Home *(Casa)*: ( )__________ Cell *(Celular)*: ( )__________ Night Phone #: ( )__________	
Mailing Address:			
School Attended by Student		**Grade:**	**School Year: 20 to 20**

Cafeteria Manager: Complete Items 8 - 15		
8) School Name (Include EEC name, if applicable)	**9) Check Site Type:** ☐ **Prep** ☐ **Satellite** ☐ **Finishing School**	
10) School Nurse	**11) School Nurse's Phone #**	**12) School Fax #**
13) Cafeteria Manager (C.M.)	**14) C.M. Email Address**	**15) Cafeteria Phone #**

Is there an IEP in place at the school that includes dietary restrictions?

Physician ONLY: Complete Items 16 - 27

16) Does the student have a disability, medical condition or severe food allergy warranting a special diet?

The disability or medical condition must limit a major life activity such as breathing or learning, and the food allergy must result in a reaction that is life-threatening and/or severely impacts the student's ability to function in school.

☐ **YES** If "YES", continue to complete the remainder of this form.
☐ **NO** **If "NO", STOP HERE. A SPECIAL DIET IS NOT WARRANTED.**

17) Disability, Medical Condition, or Severe Food Allergy: Also provide a brief description of the **major life activity** (i.e. breathing, learning) affected by the disability or **severe and/or life-threatening reaction** resulting from the food allergy.

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18) Diet Prescription: *(For carbohydrate or protein restrictions, include the level allowed for each meal)*

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19) Food Allergies: Indicate the level of sensitivity to the food(s) the child is allergic to:

☐ Omit all sources of this food **OR** ☐ Omit major sources of this food (small amounts are tolerated)

20) Food(s) to be Omitted and Suggested Substitutions:		
Food(s) to Omit	**Suggested Substitution(s)**	
21) Texture Modification: If needed, circle **one** appropriate for the student: **CHOPPED GROUND PUREED**		
22) Physician's Signature	**23) Physician's Printed Name**	**24) Medical License Number**
25) Telephone Number	**26) Date**	**27) Name & Phone of Registered Dietitian Following Student:**

RD/DTR Signature ______________________________ **Date** ___________

Send completed form to: ____

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