

Bibb County School System

DIET ORDER FORM For Students with Special Nutritional Needs

RETURN TO SCHOOL NUTRITION MANAGER

Part I: Completed by Parent or Guardian—Please PRINT

Name of Student (Last) _____ (First) _____ (MI) _____
Date of Birth ____/____/____ Age ____ Student ID # _____
School Attended by Student _____ Grade: _____ School Year: 20__ to 20__
Will student eat: Breakfast at School? Yes No / Lunch at School? Yes No / After School Program? Yes No

Name of Parent/Guardian _____ Signature _____
Mailing Address _____ City _____ State _____ Zip _____
Parent /Guardian's Phone Number(s): () ____-____, () ____-____, () ____-____,
Email: _____ **Home Work Cell**

Part II: Completed by Licensed Medical Doctor (MD) treating student—Please PRINT

Student's Disability/Diagnosis: _____
Explanation of why Disability/Diagnosis restricts the student's diet: _____

Major Life activity affected by the Disability/Diagnosis: _____

Diet Prescription

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MD indicates which dietary modification the patient needs and specifies what changes need to be made. Check all that Apply:

Texture Modification: Puree Ground Chopped Modified Thickness of Liquids
 Other _____

Nutrient Modification: (cholesterol, sodium, gluten, etc): _____

Lactose Intolerance: No milk to drink Avoid all dairy products

Diabetic (Please indicate grams of CHO at breakfast, lunch and snack)

Breakfast ____ Lunch ____ Snack AM ____ Snack PM ____

Food Allergies: ingestion contact inhalation

List foods to be omitted or avoided: _____

List foods that may be used to substitute foods that must be omitted or avoided: _____

MD Name: _____

MD Signature: _____

Phone Number: _____ **Date:** _____

Medical Office Stamp

Part III: Completed by School Food Service Personnel

Date SN Mgr. Received: _____ **SN Mgr. Initials:** _____

Date SN Office Received: _____ **SN Office Initials:** _____

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