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**

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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

REQUIRED

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: _____**
_____

Medical Office Stamp

MD Name: _____

MD Signature: _____

Phone Number: _____ Date: _____

Part III: Completed by School Food Service Personnel

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

Date SN Office Received:_____ SN Office Initials:_____