Brunswick County Schools

DIET ORDER/ MEDICAL STATEMENT

SEND COMPLETED FORM TO:
The SCHOOL NURSE
OR
BCS CHILD NUTRITION DEPT.
35 Referendum Drive, Bolivia, NC 28422
PH: 910-253-1098 FAX: 910-253-2876

NOTE: *If the child's location or needs are adjusted or changed, an updated Diet Order from the physician is required.*

Part I (to be filled out completely by parent or guardian)

Name of Student (Last)_____(First) _____(MI) _____

Date of Birth_____/_____/_____ Age _____ Student ID #(PowerSchool#)_____

School Attended by Student _____Grade:_____ School Year: 20__

Which school meals will the student be eating: ☐**BREAKFAST** ☐**LUNCH** ☐**AFTER SCHOOL SNACK**

Parent/Guardian(**print**)_____Email _____

Parent/Guardian Phone Number(s)_____(H)_____(W)_____(C)

Mailing Address: _____City:_____ State _____ Zip _____

• PARENTAL RELEASE OF INFORMATION: I give Brunswick County Schools Exceptional Children's Department, School Nurse and/or Child Nutrition Department permission to speak to the below-named licensed physician to discuss the dietary needs described below.

Parent/Guardian signature:_____ Date:_____

Part II (MUST be completed by a licensed physician only)

DIAGNOSIS:_____

Does the child have an identified disability? Yes _____No_____ Describe the major life activities affected by the disability:_____

_____Specify any dietary restrictions or special diet instructions for school meals:_____

_____

_____

MODIFICATIONS:

DESIGNATE CONSISTENCEY REQUIREMENTS FOR FOODS:

☐ Clear liquid	☐Pureed	☐Blenderized Liquid
☐Full Liquid	☐Mechanical Soft	☐Chopped

DESIGNATE CONSISTENCEY REQUIREMENTS FOR LIQUIDS:

☐Thin	☐Honey-like
☐Nectar-like	☐Spoon-Thick

DIABETES: Please indicate the grams of carbohydrates for: Breakfast _____ Lunch:_____

FOOD ALLERGIES: If student has **LIFE THREATENING/ANAPHYLACTIC** allergic reactions, check appropriate box: ☐Ingestion ☐Contact ☐Inhalation ☐All

CHECK FOOD ALLERGY: ☐Peanut ☐Tree Nuts ☐Milk ☐ Egg ☐ Wheat ☐ Soy ☐ Fish ☐ Shellfish ☐ Other_____

*For any special diet, list specific foods to be omitted and suggested substitutions; You may attach a separate page with additional information.

FOODS TO BE OMITTED:	**SUGGESTED SUBSTITUTIONS:**
_____	_____
_____	_____
_____	_____
_____	_____

Physicians (MD) Name:_____

Physicians Signature:_____

Phone#:_____ **FAX**_____

Date:_____

MEDICAL OFFICE STAMP REQUIRED

PART III (School Nurse)

Date Received:_____School Nurse:_____

PART IV (Child Nutrition Department to complete)

BCS Child Nutrition Department Notes:

Child Nutrition Administrator Signature:_____Date:_____