Statement for Students with Special Dietary Needs In Child Nutrition Programs

Student's Name: ______________________ **Age:** ________

School Name: ______________________ **Grade:** ______ **Classroom:** ________

Guardian Name: ______________________ **Phone:** ______________

Please check one box below:

A. Does the student have one or any of the following: disability / food allergy / medical condition that requires the student to have a special diet or feeding equipment/utensils?

☐ **Yes** ☐ **No (**If No, please skip to "b".)

If Yes, describe the disability and the major life activity affected by the disability. The form must be signed by a physician. Return to the school's cafeteria manager when completed.

Describe the disability/diagnosis: ______________________

B. Please list any other reason for a special dietary need. ______________

Describe the reason for the special dietary need. Return it to the school's cafeteria manager when completed. Your request will be reviewed for consideration.

Diet Prescription: (use back of form if more space is needed)

List Food Allergies/Intolerances (list specific foods(s) to be omitted): ______________

List Allowable Food Substitutions: ______________________

Indicate any texture modifications and which foods need to be modified:

☐ Chopped: ______________________

☐ Ground: ______________________

☐ Pureed: ______________________

☐ Liquid Modifications: Honey / Nectar / Other (specify) ______________

Additional comments about the student's eating patterns or dietary modifications:

Physician's or Medical Authority's: ______________________ Date: ________

Signature

______________________ Phone: ______________

Please Print