Bibb County School System

DIET ORDER FORM
For Students with Special Nutritional Needs

RETURN TO DISTRICT REGISTERED DIETITIAN DALIA KINSEY
DALIA.KINSEY@BCSDK12.NET

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
□ Nectar □ Honey □ Pudding
□ **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 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:**_________

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