

STUDENT'S NAME _____ Date of Birth _____ ID # _____
 School _____ Grade _____

List the child's physical, mental or dietary impairment that restricts the child's diet or major life activity (REQUIRED):

Please fill out all information in each applicable section. A substitution for milk is REQUIRED. Please indicate if items such as dairy, eggs, milk CAN or CANNOT be baked into products /or as an ingredient.

I. Food Allergy or Intolerance **Not Applicable**
Does the child have an Epi Pen at the Campus? YES NO

Liquid Cow's Milk Allergy (specify the following): *Liquid Milk Substitution (REQUIRED): _____

Dairy Allergy (specify the following): No Yogurt No Cheese No Sour Cream No Butter
 No dairy/milk products allowed baked in

Egg Allergy (specify the following): No Whole Eggs No Egg Whites No eggs allowed baked in

No Wheat **No Gluten/Celiac Disease** **No Peanut** **No Tree Nut** **No Fish** **No Shellfish**

No Soy Protein/Flour **No Soy Oil/Lecithin** **No Whole Kernel Corn** **No Corn Flour**

Other (Please list): _____

Please identify appropriate substitutions for the foods to omit above, if appropriate: _____

***Note: The Student Nutrition Dept. will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability.**

II. Texture Modification: **Not Applicable**

<u>Liquids:</u>	<u>Solids:</u>
<input type="checkbox"/> Thin (Regular liquids)	<input type="checkbox"/> Mechanical Soft (chopped)
<input type="checkbox"/> Nectar Thick	<input type="checkbox"/> Mechanical Soft (ground)
<input type="checkbox"/> Honey Thick	<input type="checkbox"/> Pureed (Applesauce texture)
<input type="checkbox"/> Pudding Thick	

III. Therapeutic Diet Order: **Not Applicable**
 Please state therapeutic diet: _____

I certify that the above-named student needs to be offered food substitutions as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated.

Prescribing Physician/Medical Authority _____

Printed Name of Medical Authority _____ DATE _____ MD DO PA NP SLP

Name of Practice _____ Phone Number _____

I understand that if my child's medical or health needs change, it is my responsibility to alert the student nutrition department of the changes. I also give permission for the department personnel responsible for implementing my child's special diet to discuss my child's special dietary accommodations with my child's medical authority.

_____	_____
PARENT/GUARDIAN SIGNATURE	DATE
_____	_____
EMAIL	CONTACT NUMBER OF PARENT/GUARDIAN

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 Received by: _____ Date: _____

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