Alto INDEPENDENT SCHOOL DISTRICT - CHILD NUTRITION

Phone-936-858-7126 # SPECIAL DIET ORDER FORM **Fax 936-858-4387**

To be completed by a recognized medical authority such as a licensed physician, physician's assistant or nurse practitioner

Student Name:	Parent Name:
Birth date:	Address:
School:	
Grade:	Daytime phone:
Teacher:	

Diet modifications for a disability, medical condition, allergy or food intolerance will only be made when the need is certified by a licensed medical authority. This information will be good for 1 school year and will be required to be done yearly.

<u>*Required information</u>

*** Child's disability or diagnosis ____**

***describe the major life activity or reactions affected by the disability or diagnosis:**

____

***IS THIS A LIFE THREATENING CONDITION? Circle YES NO**

***Does the child require special meals? YES NO**

***Student is competent to make appropriate food choices? YES NO *Please submit a diet plan or complete the following:**

FOODS TO BE OMITTED	ALLOWABLE SUBSTITUTIONS

I certify that the above named student needs special school meals as described above, due to the student's disability or medical condition.

*Signature of Authorized Medical Authority	Phone number	Date
Signature of Parent		Date

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