BARREN COUNTY SCHOOLS
SPECIAL DIET STATEMENT

Part 1: Student Information
Parent or Guardian Must Complete. Please Print.

Student's Name: Last / First / Middle Initial	Date of Birth:

Parent/ Guardian Name:	Work/Home/Cell Phone Numbers

Name of School	Cif#

Meals or snacks to be eaten at school/center/site: (circle all that apply)

Breakfast Lunch After school Care Program (snack)

Part 2: Student Status
Licensed Physician Must Complete. Please Print.

Section A:

☐ **Student has a disability and requires a special diet or food accommodation.** An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the American with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits one or more major life activities.

PLEASE NOTE: a food allergy **is** considered to be a disability when it results in a life-threatening (anaphylactic) reaction.

Identify the Student's disability: _____ AND/OR

Identify the Food allergy that is life-threatening/anaphylactic reaction. (considered a disability):

_____

☐ Has Epi pen _____

Section B:

☐ **Student does not have a disability but is requesting a special meal or dietary accommodation.**

☐ **Lactose Intolerance:** ☐ No milk to drink (Schools offer lactose-reduced or lactose-free milk as required by state law)

☐ **Food Intolerance:** Food(s) intolerant to: _____

☐ **Food Allergy:** Food(s) allergic to: _____

PLEASE NOTE: The student's allergy to the food(s) stated above **does not** result in a life threatening (anaphylactic) reaction.

Part 3: Dietary Accommodation Foods to be Allowed and Food to Be Omitted
Licensed Physician Must Complete. Please Print.

♦ The school cannot guarantee that the facility or dining area will be allergen free. ♦

List specific foods to be omitted. You may attach a sheet with additional information.

Bread/Grain		
Milk		
Fruit/Vegetables		
Meat/Meat Alterative		
Other		

☐ Texture Modification: _____Pureed _____Ground _____Bite-Sized Pieces _____Other (specify)

_____

☐ Other Dietary Modification OR Additional Instructions. Please include any restricted meal patterns (describe):

_____

_____

(attach specific diet order instructions)

Signature of Licensed Physician

Licensed Physician Name/Credentials (print): _____

Signature: _____ Date: _____

Clinic Name: _____

Phone: _____ Fax: _____