

Return completed form to:
 Oldham County School Nutrition
 6165 W. Highway 146
 Crestwood, KY 40014
 Fax: 502-241-3209
 Email: carlina.loyd@oldham.kyschools.us

School Year _____

OLDHAM COUNTY PUBLIC SCHOOLS SPECIAL DIETARY NEEDS AND/OR ACCOMMODATIONS REQUEST

PART A: Parent / Guardian: Complete Items 1 - 6			
1. School/Name			
2. Student's Full Name		3. Student's Date of Birth	
4. Name of Parent or Guardian		5. Telephone Number	
6. Check All that Apply: <input type="checkbox"/> Parent's request is not due to a medical disability. Please Note: Nutrition Services will attempt to accommodate cultural/personal preferences but are not required by law to do so. These accommodations depend on product availability. <input type="checkbox"/> Vegan <input type="checkbox"/> Vegetarian <input type="checkbox"/> No Pork <input type="checkbox"/> No Beef <input type="checkbox"/> Other _____ Does the student have an IEP or 504 Plan? <input type="checkbox"/> IEP <input type="checkbox"/> 504 <input type="checkbox"/> No Parent / Guardian Signature (required for processing): _____ Date: _____			
PART B: Completed by a licensed physician, physician assistant, or nurse practitioner: Complete Items 7 – 17			
7. Check One:			
<input type="checkbox"/> Student has a disability or a medical condition that requires a special meal and/or accommodation. Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment.			
<input type="checkbox"/> Student does not have a disability but is requesting a special meal or accommodation due to a food intolerance or other medical reason. Food preferences are not an appropriate for this section of the form.			
8. The student's disability or medical condition requiring a special meal or accommodation:			
9. If the student has a disability, provide a brief description of his/her major life activity affected by the disability:			
10. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):			
11. Indicate food texture for above participant:			
<input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed			
12. Foods to be omitted and substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):			
A. Foods To Be Omitted		B. Suggested Substitutions	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
13. Adaptive equipment to be used:			
14. Signature of Health Care Provider	15. Printed Name	16. Telephone Number	17. Date