

**Dietary Accommodations
for Students with Allergies and/or Medical Problems**

Physician: Please check one of the following boxes to indicate the type of dietary accommodation

Disability – A physical or mental impairment which substantially limits one or more major life activities, a record of or actually having such an impairment. It can include temporary disabilities, i.e. oral surgery or a severe food allergy resulting in anaphylaxis.

Food Service IS required to accommodate.

Medical/Dietary Need – Includes food allergies or intolerances which are **NOT life threatening.**

Food Service IS NOT required to accommodate.

**FIGURE 1. EATING AND FEEDING EVALUATION:
CHILDREN WITH SPECIAL NEEDS**

PART A			
Student's Name		Age	
Name of School		Grade Level	Classroom
Does the child have a disability? If Yes, describe the major life activities affected by the disability.		Yes	No
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.		Yes	No
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority.		Yes	No
If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service.			
PART B			
List any dietary restrictions or special diet.			
List any allergies or food intolerances to avoid.			
List foods to be substituted.			
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground: Pureed:			
List any special equipment or utensils that are needed.			
Indicate any other comments about the child's eating or feeding patterns.			
Parent's Signature		Date:	
Physician or Medical Authority's Signature		Date:	

FIGURE 2. INFORMATION CARD

Student's Name		Teacher's Name	
Special Diet or Dietary Restrictions			
Food Allergies or Intolerances			
Food Substitutions			
Foods Requiring Texture Modifications:			
Chopped:			
Finely Ground:			
Pureed or Blended:			
Other Diet Modifications:			
Feeding Techniques			
Supplemental Feedings			
Physician or Medical Authority:			
Name			
Telephone			
Fax			
Additional Contact:		Additional Contact:	
Name		Name	
Telephone		Telephone	
Fax		Fax	
School Food Service Representative/Person Completing Form:			Date:
Title			
Signature			

I give the school permission to contact the physician if they have any questions regarding the implementation of these dietary instructions.

Parent's Signature

Date

