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

<table>
<tr><td colspan="2">Student's Name</td><td colspan="2">Teacher's Name</td></tr>
<tr><td colspan="4">Special Diet or Dietary Restrictions</td></tr>
<tr><td colspan="4">Food Allergies or Intolerances</td></tr>
<tr><td colspan="4">Food Substitutions</td></tr>
<tr><td colspan="4">Foods Requiring Texture Modifications:

Chopped:

Finely Ground:

Pureed or Blended:</td></tr>
<tr><td colspan="4">Other Diet Modifications:</td></tr>
<tr><td colspan="4">Feeding Techniques</td></tr>
<tr><td colspan="4">Supplemental Feedings</td></tr>
<tr><td colspan="4">Physician or Medical Authority:
Name

Telephone

Fax</td></tr>
<tr><td colspan="2">Additional Contact:
Name

Telephone
Fax</td><td colspan="2">Additional Contact:
Name

Telephone
Fax</td></tr>
<tr><td colspan="3">School Food Service Representative/Person Completing Form:
Title

Signature</td><td>Date:</td></tr>
</table>

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