Darlington County School District
School Food Services (843) 398-2315

Diet Order for Children with Special Needs

Medical Statement

Part I (to be filled out by parent or guardian)

Name of Student: (LAST) _____(FIRST)_____ (MI) _____

Social Security Number _____- _____ - _____ Date of Birth ____/_____/_____ Age _____

School Attended by Student _____

Name of Parent or Guardian(s) _____Home Phone Number _____

Signature of Parent/Guardian _____Cell Phone Number _____

Part II (to be filled out by Physician)

Patient's Diagnosis _____

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification: _____

_____

_____

List and describe any special diet or dietary restrictions: _____

_____

Specify changes needing to be made as relative to special diet or dietary restrictions below:

- List any allergies or food intolerances to avoid: _____
  _____
- List foods to be omitted:
- List foods to be substituted:
- Circle if texture modification necessary: Pureed Ground Chopped
- List any special meal time equipment:
- Special medical comments about the child's eating or feeding patterns:

Please attach additional information available or needed to this form.

Dietitian's Name (if available): _____ Phone _____

Physician's Name _____Phone _____

Address _____

_____

Signature of Physician _____Date _____

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Diet Order for Children with Special Needs

Purpose: to record the student's condition requiring dietary modifications of school meals and the changes needed.

Preparation: The parent or guardian of the child is responsible for obtaining the form, filling out Part I, requesting completion by a physician, and delivering the form to the school. A licensed physician is responsible for completing Part II of the document based on the child's medical condition.

INSTRUCTIONS:

Part I (to be filled out by parent or guardian)

Name of Student: Enter the student's last name, first name, and middle initial.

Social Security Number: Enter the student's nine-digit social security number.

Date of Birth: Enter the student's six digit date of birth.

Age: Enter the student's one or two digit AGE.

School Attended: Enter the name of the school the student regularly attends.

Parent/Guardian Phone Numbers:
If available, enter home or work and cell phone numbers with the area code where parent or guardian can be reached in the day time.

Name of Parent/Guardian: Enter the full name of the student's parent(s) or legal guardian(s)

Signature of Parent/Guardian:
Enter the signature of one parent or legal guardian's name.
The printed name on the previous line should correspond to the signature.

Part II (to be filled out by licensed physician)

Patient's Diagnosis: Insert the patient's clinical diagnosis for the condition which requires dietary modification.

Description of patient's condition and major life activity affected by the condition related to dietary modification: Describe the patient's condition as it affects a major life activity.
Describe how the restrictions of the patient's condition affect his/her diet.

Indicate which dietary modifications the patient needs and specify what changes need to be made:
Check the type(s) of modification the patient's condition requires and fill in the corresponding specification next to the type of modification.

Dietitian's Name/Phone Number (if available):
Provide a local dietitian's name and phone number if available.

Physician: Print the name, address, and phone number of the physician completing form.

Physician's Signature/Date Signed:
Enter the signature of the physician filling out the form and the date signed.

RETURN COMPLETED FORM TO:
THE PRINCIPAL, SCHOOL NURSE, OR CAFETERIA MANAGER AT YOUR CHILD'S SCHOOL