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 _____