

Special Diet Form

☐

New

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Change/Modify

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Temporary (End Date: _____)

STUDENT INFORMATION

First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Male / Female: _____

Student ID Number: _____ School Name: _____ Today's Date: _____

MEDICAL INFORMATION

Per the United States Department of Agriculture, a person with a disability is any such person who has an impairment that substantially limits one or more life activities. By definition this includes but is not limited to diabetes, PKU, celiac disease, food anaphylaxis, learning disabilities, and etc.

THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN ONLY.

Patient Diagnosis/Medical Condition: _____

Is patient diagnosis considered a disability? _____ YES _____ NO (DR. INITIAL ONLY)

If yes, please describe major life activities affected in relation to dietary modification: _____

Texture Modification: Ground ☐ Chopped ☐ Pureed _____ Other (please be specific): _____

Tube Feeding: Formula Name: _____ Instructions: _____ Oral? _____ YES _____ NO

Nutrient Modification: Increase Calories _____ Decrease Calories _____ Nutrient Restriction _____

Omit Foods: _____ Substitute with: _____

Does patient have a life threatening food allergy? _____ YES _____ NO (DR. INITIAL ONLY)

Food Allergies (check all that apply):

☐ Fluid Milk ☐ All Dairy Products ☐ Soy ☐ Eggs ☐ All Products With Eggs ☐ Wheat
☐ Gluten
☐ Corn ☐ All Corn Additives ☐ Seafood ☐ Peanuts ☐ All Nuts ☐ All Foods Produced in

Facility With Nut Products

Other: _____

Can patient consume allergen as an ingredient in food product? _____ YES _____ NO (DR. INITIAL ONLY)

Physician Name: _____ Phone: (_____) _____ - _____

Physician Signature: _____

Any change of treatment must be requested in writing on this form. Once form is submitted, please allow up to five days for processing. Send completed form to the school cafeteria, nurse's office, or deliver to Food & Nutrition Service Office 419 Bois D'Arc St, Lockhart, TX 78644.

By signing below, I understand that it is my responsibility to renew this form anytime my child's medical or health needs change.

Parent Signature: _____ Date: _____