



SIGNATURE PREPARATORY

SPECIAL DIET FORM – NUTRITION SERVICES

Please Return Form to Health Office

Student Name: _____ DOB: _____ Year: _____

School: Signature Preparatory Grade: _____ Home Room: _____

PART A – Please complete this form if your child requires special meals.

Current information must be submitted at the beginning of each school year

Does the child have a disability as defined in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990?	Yes	No
Does the child have special nutritional or feeding needs? If Yes, have Health Care Provider complete and sign Part B.	Yes (Special Nutritional Needs)	No (Special Nutritional Needs)

PART B – TO BE COMPLETED BY A PHYSICIAN OR PRESCRIBING HEALTH CARE PROVIDER

Please ☒ check mark any food allergies or intolerances child has and list the foods that are to be omitted & substituted.
Please make notation if it is a SEVERE/LIFE-THREATENING allergy (Epi-pen prescribed for possible anaphylactic reaction)

MILK ALLERGY ☐ SEVERE/LIFE-THREATENING ☐ Milk and uncooked dairy products only (Ex. Fluid milk, yogurt, cheese, etc.) ☐ Milk, dairy, and ALL milk products (includes cooked & denatured milk products. Ex. Breads, cookies, etc.) ☐ Fluid milk only ☐ Lactose Intolerant Foods to be omitted: _____ Substitutions: _____	EGG ALLERGY ☐ SEVERE/LIFE-THREATENING ☐ Eggs only (Ex. Boiled, scrambled, individualized eggs) ☐ Eggs and ALL egg products (This includes cooked and denatured egg products. Ex. Breads, muffins, etc.) Foods to be omitted: _____ Substitutions: _____
NUT ALLERGY ☐ SEVERE/LIFE-THREATENING ☐ Peanuts ☐ Tree nuts ☐ All nuts ☐ Other ☐ Foods to be omitted: _____ ☐ Substitutions: _____	SOY ALLERGY ☐ SEVERE/LIFE-THREATENING ☐ Soy only (Ex. Soy milk, soy yogurt, etc.) ☐ Soy and ALL soy products (This includes cooked and denatured soy products. Ex. Taco meat, chicken tenders, burger patty, etc.) Foods to be omitted: _____ Substitutions: _____

OTHER ALLERGIES/FOOD INTOLERANCES

Foods to be omitted (Non-life threatening): _____

Foods to be omitted (Life-threatening): _____

List any special equipment/utensils needed:

Do foods need to be modified in texture? If yes, please describe the modifications needed (i.e. chopped, finely ground, pureed, etc.): If diet needs to be chopped, please specify the dimensions or size of the food portions/pieces:	Yes	No
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Consistency of food? (e.g., according to IDDSI Framework):

Additional Dietary Restriction or Special Diet or Comments on child's eating/feeding concerns? Please describe.

Parent/Guardian Signature	Phone	Date
Physician, or Medical Authority's Signature	Phone	Date

☐ Reviewed by school nurse & forwarded to Nutrition Services on _____ (date) _____ (School Nurse Signature)