



EXCEPTIONAL STUDENTS DEPARTMENT

Diet Order Form

Annual Medical Statement for Students with Special Nutritional Needs

Send completed form to: School Nutrition Manager at your child's school

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

Name of Student (Last) _____ (First) _____ (MI) _____

Date of Birth: ____ / ____ / ____ Age: ____ Student ID#: _____

School Attended by Student: _____

Grade: _____ School Year: 20 ____ to 20 ____

Will student eat Breakfast at School? ☐ Yes ☐ No

Will student eat Lunch at School? ☐ Yes ☐ No

Is student in Before School Program? ☐ Yes ☐ No

After School Program? ☐ Yes ☐ No

Parent/Guardian's Phone Number (s) (H) _____ (W) _____ (Cell) _____

Mailing Address _____ City/State _____ Zip _____

Name of Parent / Guardian

Signature

Part II (to be filled out only by Licensed Medical Doctor (MD) or Registered Dietitian (RD) treating the student)

Student's Diagnosis _____

MD Indicate which dietary modification the patient needs and specify what changes need to be made:

Texture Modification: ☐ Pureed ☐ Ground ☐ Chopped
☐ Other _____

Nutrient Modification: (Cholesterol, sodium, gluten, etc): _____

Lactose Intolerance: ☐ No milk to drink ☐ Juice in place of milk at meals
☐ Avoid all dairy products

Diabetic (Please indicate grams of carbohydrate at breakfast and lunch) _____

Food Allergies (Please check appropriate box(es))

☐ Ingestion ☐ Contact ☐ Inhalation

List foods to be avoided: _____

REQUIRED

MD name _____

MD Signature _____

Phone _____ Date _____

OR

RD name _____

RD Signature _____

Phone _____ Date _____

Medical Office Stamp:

Part III (to be filled out by School Nutrition)

School Nutrition Program Notes:

SNP Coordinator's Signature _____

Date _____

Information provided on this form will be used by School Nutrition personnel to prepare and service the student's special diet. Information will not be released except to those responsible for the student's meal.

PURPOSE:	To record the student's condition requiring dietary modifications of school meals and the changes needed. This form must be completed at the start of each school year and whenever diagnosis or change is indicated. Annual completion of this form by the child's Medical Doctor (MD) or Registered Dietitian (RD) ensures that current nutritional needs are being met.
PREPARATION:	The parent or guardian of the child is responsible for obtaining the form, filling out Part I, requesting completion by the student's physician or dietitian, and delivering the form to the Manager at the child's school. A licensed physician or registered dietitian is required to complete Part II of the document based on the child's medical condition and attach the diet and list of allowed substitutions.

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.

Date of Birth: Enter the student's six digits date of birth, e.g. May 1, 1988 = 050188.

Age: Enter the student's current age and Student ID#.

School Attended by Student: Enter the name of the school, which the student regularly attends, grade, and school year and indicate if child eats Breakfast and or lunch in school cafeteria.

Parent / Guardian's Phone Number(s): If available, enter one or two telephone numbers with the area codes where a parent/guardian can be reached during the daytime: home, work, and cell number.

Mailing Address: Print address and include zip code.

Name of Parent / Guardian(s): Print 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. A printed name on the previous line should correspond to the signature.

Part II (to be filled out by the Physician (MD) or Registered Dietician (RD) treating the student)