THE PLACE TO BE

LANCASTER CITY SCHOOLS

Dietary Accommodations Form

Name of Student: ______________________ **Date of Birth:** __________ **Date:** __________

School Attended by Student: ______________________

TO BE COMPLETED BY MEDICAL PROVIDER:
Please be specific as possible and please attach any additional instructions on a separate sheet as applicable.

State the physical or mental condition/impairment(s) that affects student's diet (required):

____

Describe how the physical or mental condition/impairment(s) listed restricts the student's diet (required):

____

List foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted (Avoid specific brand names if possible)

****Can the allergen be baked in?** ___ **Yes** ___ **No**

Additional Modifications (complete as applicable):

Texture Modification (if applicable):
List foods that need the following change in texture. If all foods are to be prepared in the manner, indicate "all"
Pureed: __________ Ground: __________ Chopped/cut up into bite size pieces: __________

Liquid Consistency (if applicable): ___ Pudding ___ Honey ___ Nectar ___ Other (Please describe)__________

Adaptive Equipment (If Applicable): List any special equipment or utensils that are needed: __________

Additional Instructions/Comments: ______________________

Required Signature:
This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse. The medical authority should retain a copy of this document for their records.

Prescribing Authority Name & Credentials (print): ______________________

Signature: ______________________ **Date:** ______________________

Phone Number: ______________________ **Fax Number:** ______________________

Parent Signature: ______________________ **Date:** ______________________

School Official Signature: ______________________ **Date:** ______________________

___ Parent ___ Principal ___ General Education Teachers ___ Food Services ___ Student Health Record