Cincinnati Public Schools
Student Dining Services - Special Dietary Needs Form

The U.S. Department of Agriculture School Meals Programs requires this form to be completed
in order for a reasonable diet modification to be made in school meals.

STUDENT'S NAME (LAST,FIRST)	STUDENT'S DATE OF BIRTH	SCHOOL YEAR

I give CPS SDS permission to speak with medical authority about dietary needs as ordered. I understand that I may refuse to sign this authorization without impact on the eligibility of my request. I understand that I may rescind permission to release this information at any time, except when the information has already been release.

□ NEW request
□ CHANGE request
□ DISCONTINUE request

PARENT/GUARDIAN SIGNATURE   PHONE NUMBER   DATE

Section A. To Be Completed By Medical Authority (MD, PA or NP)

Does the student have a disability which restricts the student's diet?   ☐ Yes, continue with this section   ☐ No, refer to section B

*If yes, major life activities affected by the disability:

□ eating	□ hearing	□ breathing	□ learning	□ other
□ seeing	□ speaking	□ walking	□ care for one's self	

I. Food Allergy or Intolerance Affecting Major Life Activities:

Milk Allergy
☐ Avoid all dairy products or specify below
  □ avoid cheese
  □ avoid yogurt
  □ avoid fluid milk -- substitute with: □ water
         □ soy milk

Lactose Intolerance:
☐ Avoid all dairy products or specify below
  □ avoid cheese
  □ avoid yogurt
  □ avoid fluid milk -- substitute with: □ water
         □ soy milk

Egg Allergy:
☐ Avoid all egg products or specify below
  □ avoid whole egg (scrambled or boiled)
  □ avoid egg as an ingredient (baked goods)

☐ Peanut   ☐ Tree Nut   ☐ Fish   ☐ Shellfish   ☐ Wheat   ☐ Soy   ☐ Sesame

☐ Other:_____

II. Texture Modification of District Provided Food:

Liquids:
□ thin liquids (regular)
□ nectar thick
□ honey thick
□ pudding thick

Solids:
□ regular
□ mechanical soft - chopped
□ mechanical soft- ground
□ pureed- applesauce texture

Special Utensils Needed:_____

III. Recommended Substitute or Other Nutrition Requirements:

MEDICAL AUTHORITY NAME (PRINTED)

MEDICAL AUTHORITY SIGNATURE   PHONE NUMBER   DATE

Section B. To be Completed by Parent/Guardian

Does the student have a dietary preference?   ☐ Yes   ☐ No

USDA restricts menu modifications due to preference ; however, CPS SDS plans menu to offer a variety of choices daily to accommodate dietary needs

☐ Milk Intolerance or specify below
  □ avoid cheese
  □ avoid yogurt
  □ avoid fluid milk -- substitute with water

☐ Vegetarian   ☐ No Beef   ☐ No Chicken   ☐ Other:_____

☐ Vegan   ☐ No Pork   ☐ No Turkey

Return completed form to: cpsfs@cpsboe.k12.oh.us