



All sections must be completely filled out before the form is accepted. Accommodations may take up to 15 business days to begin.

If your student has a milk allergy or medical condition that requires a milk substitution, please complete Part B (Milk Substitution Section) of this form. For students whose disabilities restrict their diets, a medical statement signed by a licensed physician is required. Please have your physician complete Part C (Licensed Provider Section) of this form. Once completed, return the form to the School Nurse, who will forward it to the FWCS Nutrition Services Registered Dietitians for review.

Part A - To be completed by Parent/Guardian
Student's Name (Last): _____ (First) _____ Date of Birth: ___/___/___
Student ID: _____ School: _____ Grade: _____ Teacher: _____
Which meals will the child eat at school (circle all that apply)? Breakfast Lunch Snack
Disability / Medical Need of Student: Allergy Intolerance
Parent/Guardian Name (please print) _____ Phone# _____
I agree to give the Nutrition Services Department and School Nurse permission to speak with the below named Healthcare Provider to discuss the dietary needs described below.
Parent/Guardian Signature: _____ Date: _____

Part B - Milk Substitution Section
Please complete this section of the form for students who are requesting a milk substitution only. If the student needs to request more extensive meal accommodations, these types of accommodations require a physician's signature and part C of this form to be completed.
Does the student have a milk disability or allergy that requires the student to have a milk substitute? yes no
Explain why the student needs a milk substitution (reason for request). _____
Soy milk is offered as the the approved milk substitution, is this acceptable? yes no

Part C - To be completed by a Licensed Provider - MD, DO, NP, PA, or RD
Medical Diagnosis/Condition : _____
Does the child have a life-threatening food allergy? yes no Needs EpiPen?
Child has allergic reaction if item is: Ingested Contact Inhaled
Describe the signs/symptoms that occur if the student comes in contact with the food allergen: _____
Foods that should be avoided: Check all that apply
Dairy: Fluid Milk Only (ok with dairy as ingredient) All Dairy Products (Yogurt, Cheese, Butter) All Milk Proteins (Casein, whey, or any recipe with milk as ingredient)
Egg: Whole Egg (scrambled or boiled) All Egg Protein (Any recipe with egg as ingredient)
Fish or Shellfish: Specify _____
Sesame: All Sesame
Wheat/Gluten: Recipes with any wheat listed as ingredient.
Nuts/Soy: Peanuts Tree Nuts (Cashews, Almonds, Walnuts) Soy Protein (any recipe with soy protein) ok with soy as an ingredient (soy oil/soy lecithin)
Other (be specific - whole food, as ingredient, or both) _____
This diet order is: Permanent (Remains in effect while the student is enrolled in FWCS. Any changes require a new diet order. Temporary (effective for the current school year. A new form will be required annually).
Name of Healthcare Provider (Please Print): _____ Phone# _____
Healthcare Provider Signature: _____ Date: _____

Submit completed forms to your School Nurse's office. For questions or concerns, contact Nutrition Services at 260-467-2500
USDA is an equal opportunity provider, employer, and lender.