York County School Division
yorkcountyschools.org

Special Dietary Needs Request

Part A	
Student's Name:	Age:
Name of School: Teacher:	Grade:
Question: Does the child have special nutritional or feeding needs? Yes No If Yes, complete **Part B** of this form and have it signed by a *licensed physician or nurse practitioner* ***This information will be shared with cafeteria and other pertinent staff members***	
Part B	
List any dietary restrictions or special diet.	
List any FOOD allergies or FOOD intolerances to avoid.	
List foods to be substituted.	
List any foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All' ☐ Cut up or chopped into bite size pieces ☐ Finely ground ☐ Pureed	
Indicate any other comments about the child's eating or feeding patterns.	
Parent/ Guardian Signature: Phone:	Date:
Licensed Physician's Signature: Phone:	Date: