Farmington Municipal Schools Health Services
Eating & Feeding Prescription for Students with Special Dietary Needs

Student Name_____ Student ID_____ DOB_____

School _____ Grade_____ Teacher_____

Medical Provider: _____ Date: _____

1. Specify: ☐ Medical condition **OR** ☐ Disability requiring restricted or modified diet*

*If disability, state major life activity affected: _____

2. Food Intolerances (Digestive System Response) (**Milk Preference DOES NOT require a Medical Provider's signature)**

FOODS TO OMIT	FOOD THAT CAN BE SUBSTITUTED
☐ Dairy Milk	☐ Almond Milk ☐ Soy Milk ☐ Oat Milk

(ALL OTHER FOOD SUBSTITUTIONS FOR FOOD INTOLERANCES MUST HAVE A MEDICAL PROVIDER'S SIGNATURE)

FOOD TO OMIT	FOOD THAT CAN BE SUBSTITUTED

3. Food Allergies (Immune System Response)

FOOD STUDENT IS ALLERGIC TO	REACTION ☐ Epi-Pen Needed

☐ Special Diet Requested (**YOU MUST HAVE A MEDICAL PROVIDER'S SIGNATURE FOR A SPECIAL DIET)**

List Special Diet Here _____

5. Duration of Procedure or Special/Modified Diet:

☐ Entire School Year **OR** ☐ Specified Dates _____ to _____

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6. Select the following modifications needed:

- ☐ Cut up or chopped into bite-sized pieces
- ☐ Finely ground
- ☐ Soft
- ☐ Pureed
- ☐ Nectar Thick Liquids
- ☐ Honey Thick Liquids
- ☐ Pudding Thick Liquids

7. List any special equipment or utensils needed: _____

8. Indicate any other comments about the student's eating or feeding: _____

_____

Parent/Guardian Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

PARENTS PLEASE NOTE: Your dietary request **cannot be honored** until the School Nurse receives an order from your medical provider. Until we receive orders, PARENTS WILL BE RESPONSIBLE FOR PROVIDING FOOD FOR YOUR CHILD TO CONSUME AT SCHOOL. Your School Nurse will alert you of the date when your school cafeteria will provide your child's meals. Thank you for your cooperation. Please contact your School Nurse if you have questions.