



PART A Parent / Guardian: Complete Items 1 - 16 (Padre/madre/tutor: complete la información en los espacios 1 al 16)

1) Student ID# (Numero de estudiante)	2) Student's Last Name (Apellido)	3) Student's First Name (Nombre del estudiante)	4) Date of Birth (Fecha de nacimiento)

5) School (Escuela)	6) Grade (Grado)	7) Student assigned in:
		☐ ECAP ☐ Pre-K

Parent/Guardian Name & Contact Information (Nombre & Información del contacto)

8) Name (Nombre)	9) Phone Number (Teléfono)	10) Mailing Address, City, State, Zip (Dirección posta, ciudad, estado, código postal)

11) E-mail Address (Dirección electrónica)

12) Meals Eaten at School (Los alimentos que su niño(a) consumirá en la escuela) ☐ Breakfast (Desayuno) ☐ Snack (Merienda) ☐ Lunch (Almuerzo) ☐ None (Nada)	13) Parent Request: (Solicitud de los padres) ☐ Lactose Intolerance (intolerancia a lactosa) (Lactaid Milk needed) (necesita leche Lactaid) If lactose intolerant, mark if child CAN eat (marque si puede comer) ☐ Cheese (queso) ☐ Yogurt (yogur) ☐ Cultural/Religious Preference (preferencias culturales/religiosas) ☐ Vegetarian (vegetariano) ☐ No Pork (carne de cerdo) ☐ No Beef (carne de res) ☐ Other foods to exclude (otro) _____
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14) Does the student have an identified disability (IEP or 504 Plan)?
 ¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)? ☐ Yes (Sí) ☐ No

15) I consent to the exchange of information between the physician and school **district**, as needed.
 (Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)

Parent / Guardian Signature (required for processing)
 (Firma del padre/madre/tutor - requerido para ser procesado) X Date (Fecha)

16) Parent/Guardian: It is required that this completed form is returned to the School Nurse who will share information with the Nutrition Department. All further changes to the child's diet *must be made by a physician on a new form* with the exception of lactose intolerance or cultural preference.

By signing above I give Child Nutrition Services permission to speak with the Licensed Medical Doctor (MD) signing the Diet Order Form to discuss the student's dietary needs described in this form.

(Padre/madre/tutor: Se REQUIERE que se devuelva la forma debidamente completada al gerente de la cafetería. Cualquier cambio en la dieta del estudiante debe ser hecho por un médico en una nueva forma, a excepción de la intolerancia a lactosa o preferencias culturales. Al firmar arriba, doy permiso a Servicios de Nutrición Infantil para hablar con el Doctor que firma el formulario para analizar las necesidades dietéticas del estudiante.)

PART B COMPLETED BY THE PHYSICIAN ONLY: Complete Items 17 – 20 (17 al 20 - Esta sección para ser completada por el médico solamente.)

17) Student Diagnosis or Condition ☐ Food Intolerance ☐ Food Allergy
 Select One ☐ Other (specify) _____

FOOD TEXTURE MODIFICATION If medically needed check ONE: ☐ Pureed ☐ Ground ☐ Chopped

18) Please check all food(s) to **exclude** from child's diet during the school **day** only (not to be used as a medical history):

DAIRY ☐ Fluid Milk Only ☐ Cheese ☐ Ice Cream ☐ Yogurt ☐ All Milk Ingredients EGG ☐ Whole Eggs Only (such as scrambled eggs or hard cooked eggs) ☐ All Egg Ingredients WHEAT & GLUTEN ☐ Wheat ☐ Gluten FISH ☐ Fish ☐ Shellfish	PEANUTS OR TREE NUTS ☐ Peanuts ☐ Tree Nuts CORN ☐ Whole Corn (such as corn kernels, tortilla chips, corn muffin) ☐ Recipes with Corn/Corn By-Product Ingredients SOY ☐ Soy Protein Only ☐ Soybean Oil ☐ Soy Lecithin OTHER ☐ Other (specify if it is a cooked ingredient or when consumed fresh) _____ _____ _____
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20) LICENSED PHYSICIAN'S INFORMATION Diet Order Form will be returned to parent / guardian if this section is not filled in its entirety.

Medical Authority Signature X	Date 	Please contact the Capital School District Child Nutrition Office if you have any questions about completing this form. Jennifer Piasecki, Registered Dietitian jennifer.piasecki@capital.k12.de.us Office: (302) 857-4251 Fax: (302) 672-1613
Medical Authority Printed Name 		