**Dietary Accommodations**
**for Students with Allergies and/or Medical Problems**

**Physician:** *Please check one of the following boxes to indicate the type of dietary accommodation needed.*

_____**Disability** – A physical or mental impairment which substantially limits one or more major life activities, a record of or actually having such an impairment. It can include temporary disabilities, i.e. oral surgery or a severe food allergy resulting in anaphylaxis.

***Food Service IS required to accommodate.***

_____**Medical/Dietary Need** – Includes food allergies or intolerances which are ***NOT life threatening***.

***Food Service IS NOT required to accommodate.***

## FIGURE 1. EATING AND FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

| PART A | | | |
|---|---|---|---|
| Student's Name | | Age | |
| Name of School | Grade Level | Classroom | |
| Does the child have a disability? If Yes, describe the major life activities affected by the disability. | | Yes | No |
| Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician. | | Yes | No |
| If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority. | | Yes | No |
| If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service. | | | |

| PART B |
|---|
| List any dietary restrictions or special diet. |
| List any allergies or food intolerances to avoid. |
| List foods to be substituted. |
| List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."<br>Cut up or chopped into bite size pieces:<br>Finely ground:<br>Pureed: |
| List any special equipment or utensils that are needed. |
| Indicate any other comments about the child's eating or feeding patterns. |

| | |
|---|---|
| Parent's Signature | Date: |
| Physician or Medical Authority's Signature | Date: |

**FIGURE 2. INFORMATION CARD**

| | |
|---|---|
| Student's Name | Teacher's Name |
| Special Diet or Dietary Restrictions | |
| Food Allergies or Intolerances | |
| Food Substitutions | |
| Foods Requiring Texture Modifications:<br><br>Chopped:<br><br>Finely Ground:<br><br>Pureed or Blended: | |
| Other Diet Modifications: | |
| Feeding Techniques | |
| Supplemental Feedings | |
| Physician or Medical Authority:<br>Name<br><br>Telephone<br><br>Fax | |
| Additional Contact:<br>Name<br><br>Telephone<br>Fax | Additional Contact:<br>Name<br><br>Telephone<br>Fax |
| School Food Service Representative/Person Completing Form:<br>Title<br><br>Signature | Date: |



I give the school permission to contact the physician if they have any questions regarding the implementation of these dietary instructions.

_____ _____

Parent's Signature Date