



Cincinnati Public Schools

Student Dining Services - Special Dietary Needs Form

The U.S. Department of Agriculture School Meals Programs requires this form to be completed in order for a reasonable diet modification to be made in school meals.

STUDENT'S NAME (LAST,FIRST)	STUDENT'S DATE OF BIRTH	SCHOOL YEAR
I give CPS SDS permission to speak with medical authority about dietary needs as ordered. I understand that I may refuse to sign this authorization without impact on the eligibility of my request. I understand that I may rescind permission to release this information at any time, except when the information has already been release.		
☐ NEW request ☐ CHANGE request ☐ DISCONTINUE request		
PARENT/GUARDIAN SIGNATURE	PHONE NUMBER	DATE

Section A. To Be Completed By Medical Authority (MD, PA or NP)
Does the student have a disability which restricts the student's diet? ☐ Yes, continue with this section ☐ No, refer to **section B**
*If yes, major life activities affected by the disability:

☐ eating ☐ hearing ☐ breathing ☐ learning ☐ other
☐ seeing ☐ speaking ☐ walking ☐ care for one's self

I. Food Allergy or Intolerance Affecting Major Life Activities:

Milk Allergy
☐ Avoid all dairy products or specify below

☐ avoid cheese
☐ avoid yogurt
☐ avoid fluid milk -- substitute with: ☐ water ☐ soy milk

Lactose Intolerance:
☐ Avoid all dairy products or specify below

☐ avoid cheese
☐ avoid yogurt
☐ avoid fluid milk -- substitute with: ☐ water ☐ soy milk

Egg Allergy:
☐ Avoid all egg products or specify below

☐ avoid whole egg (scrambled or boiled)
☐ avoid egg as an ingredient (baked goods)

☐ Peanut ☐ Tree Nut ☐ Fish ☐ Shellfish ☐ Wheat ☐ Soy ☐ Sesame
☐ Other: _____

II. Texture Modification of District Provided Food:

Liquids:
☐ thin liquids (regular)
☐ nectar thick
☐ honey thick
☐ pudding thick

Solids:
☐ regular
☐ mechanical soft - chopped
☐ mechanical soft- ground
☐ pureed- applesauce texture

Special Utensils Needed: _____

III. Recommended Substitute or Other Nutrition Requirements:

MEDICAL AUTHORITY NAME (PRINTED)
MEDICAL AUTHORITY SIGNATURE **PHONE NUMBER** **DATE**

Section B. To be Completed by Parent/Guardian
Does the student have a dietary preference? ☐ Yes ☐ No
USDA restricts menu modifications due to preference ; however, CPS SDS plans menu to offer a variety of choices daily to accommodate dietary needs

☐ Milk Intolerance or specify below

☐ avoid cheese
☐ avoid yogurt
☐ avoid fluid milk -- substitute with water

☐ Vegetarian ☐ No Beef ☐ No Chicken
☐ Vegan ☐ No Pork ☐ No Turkey

☐ Other: _____