

STUDENT'S NAME _____ Date of Birth _____ ID # _____

School _____ Grade _____

Diagnosis or other special dietary condition which restricts diet _____

What must be done to accommodate the child: _____

I. Food Allergy or Intolerance **Not Applicable**

Does the child have an Epi Pen at the Campus? YES NO

- Milk Allergy** No liquid cow's milk
- Dairy Allergy** No Yogurt No Cheese No Sour Cream Avoid all dairy products even in baked goods
- Egg Allergy** No Whole Eggs No Egg Whites No Eggs in baked goods
- No Wheat** **No Gluten/Celiac Disease** **No Peanut** **No Tree Nut** **No Fish** **No Shellfish**
- No Soy Protein/Flour** **No Soy Oil/Lecithin** **No Corn**
- Other (Please list):** _____

Please identify appropriate substitutions for the foods to omit above, if appropriate _____

***Note: The Student Nutrition Dept. will attempt to accommodate the substitution as requested but reserves the right to modify the menu based on product availability.**

II. Texture Modification: **Not Applicable**

- | | |
|---|--|
| <u>Liquids:</u> | <u>Solids:</u> |
| <input type="checkbox"/> Thin (Regular liquids) | <input type="checkbox"/> Mechanical Soft (chopped) |
| <input type="checkbox"/> Nectar Thick | <input type="checkbox"/> Mechanical Soft (ground) |
| <input type="checkbox"/> Honey Thick | <input type="checkbox"/> Pureed (Applesauce texture) |
| <input type="checkbox"/> Pudding Thick | |

III. Therapeutic Diet Order: **Not Applicable**

Please state therapeutic diet _____

I certify that the above named student needs to be offered food substitutions as described above because of the student's disability/life threatening food allergy or food intolerance/allergy as indicated.

Prescribing Physician/Medical Authority _____

Printed Name of Medical Authority _____ DATE _____ MD DO PA NP SLP

Name of Practice _____ Phone Number _____

I understand that if my child's medical or health needs change, it is my responsibility to alert the student nutrition department of the changes. I also give permission for the department personnel responsible for implementing my child's special diet to discuss my child's special dietary accommodations with my child's medical authority.

PARENT/GUARDIAN SIGNATURE

DATE

EMAIL

CONTACT NUMBER OF PARENT/GUARDIAN

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