Child Nutrition Program
Dietary Request Form
2016 - 2017

STUDENT'S NAME (Last, First) _______________________________ ID#____________ Campus__________

TO BE COMPLETED BY PHYSICIAN OR MEDICAL AUTHORITY

Section A.

List the student's medical condition/disability (REQUIRED): ____

If the student has allergies that are life threatening/anaphylactic. Check off the following:

Dairy Allergy:	Milk Allergy:	Peanut / Tree Nut Allergy:	Corn Allergy:	Soy Allergy:	Egg Allergy:	Wheat Allergy:	Fish / Shell-fish Allergy:
□ No Fluid Dairy □ No Yogurt □ No Cheese □ Avoid ALL dairy products even in baked goods	□ No Milk *(Soy milk will be offered)*	□ No Peanut □ No Tree Nut	□ No Corn	□ No Soy	□ No Whole Egg □ No Egg Whites □ No Eggs in baked goods	□ No Wheat	□ No Fish □ No Shellfish

Other Allergy:

If the student has a food allergy/intolerance that is not life threatening. Check off the following:

□ Lactose Intolerance (Lactose-free milk will be offered)
□ Other: ________________________________

Section B.

If the student requires texture modification. Check off the following:

Liquid______ Soft______ Pureed _______

Year Round:_____ Temporary: _____ If temporary, start date: __________ end date: ________

If the student has other special dietary needs, indicate below:

Carbohydrate gram count: Breakfast _____ Lunch ______ Snack _____

Sodium Restriction: __________PKU:______________ Cardiac: _____________ Other: _________

I certify that the named student needs to be offered food substitutions because of the medical condition or disability indicated above.

Print Name of Medical Authority Signature____ Clinic Name ____________
Contact Phone Number (____)________________________ Date ___________

Note: Child Nutrition Program will attempt to accommodate the substitutions as requested, but reserves the right to modify the menu based on product availability.

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that if my child's medical needs change, it is my responsibility to provide documentation from my child's physician to the school health aide.

Parent/Guardian Signature ____ Date __________________
Address/E-mail ____
Contact Phone Number (____)____

Please return the completed form to the health aide at your child's school.

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