

Student's Name (Last, First) _____ Date of Birth _____

School _____ Grade _____ ID _____

Parent/Guardian _____ Phone _____

School Nurse _____ Phone _____

I give Health Services/ Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent/Guardian Signature Date

Section A. (To be completed by a licensed physician)
Disability or severe, life-threatening food allergy
Student's Medical Condition/Disability (REQUIRED) _____

- I. Disability or Severe Life-Threatening Food Allergy:**
Student has allergies that are life threatening/anaphylactic?
- Yes, continue with this section No, refer to section B
 - No Fluid Dairy Milk No Milk Products (yogurt, cheese, etc)
 - No Milk Protein/Milk Ingredients (in baked goods, etc.)
 - No Whole Eggs No Eggs as an ingredient
 - No Wheat/Gluten No Peanuts No Tree Nuts
 - No foods processed in a facility that contains nuts
 - No Seafood No Soy
 - Other (Please list) _____

Substitutions _____

- II. Texture Modification:**
- Year Round
 - Temporary: Start _____ Stop _____
 - Liquids:** **Solids:**
 - Thin (Regular Liquids) Mechanical Soft (chopped)
 - Nectar Thick Mechanical Soft (ground)
 - Pudding Thick Pureed (Applesauce texture)

- III. Supplement:**
- NPO Supplement to accompany oral diet
 - Boost Kid Essentials 1.0 PediaSure PediaSure w/ Fiber
 - PediaSure w/ Fiber 1.5 Other: _____

Dosage Per Meal (REQUIRED):
_____ Breakfast _____ Lunch _____ After School Snack

*Supplements not listed above may take up to 6 weeks to be processed.

IV. Therapeutic Diet Order: Please provide specifics below.

Section B. (To be completed by a recognized medical authority)
Food Allergy/Intolerance (NOT LIFE THREATENING)
Student without a disability but is requesting dietary accommodations
Please check one of the boxes below (REQUIRED):

Allergy Intolerance Other _____

- Student's allergy/intolerance to food(s) below:
DOES NOT result in a life-threatening/anaphylactic reaction*
- No Fluid Dairy Milk No Milk Products (yogurt, cheese, etc.)
 - No Milk Protein/Milk Ingredients (in baked goods, etc.)
 - No Whole Eggs No Eggs as an ingredient
 - No Wheat/Gluten No Peanuts No Tree Nuts
 - No foods processed in a facility that contains nuts
 - No Seafood No Soy
 - Other (Please list): _____

Substitutions _____

Substitutions _____

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability and/or life-threatening food allergy or food intolerance/allergy, as indicated.

Signature of Prescribing Medical Authority Date

Printed Name of Medical Authority

() - () -
Phone Fax

Address

Please fax completed form to school nurse. Physician requests must be renewed each school year. Any change in accommodations must be requested in writing by physician or authorized medical authority.

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