



Child Nutrition Program Dietary Request Form 2017 - 2018

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:
<input type="checkbox"/> No Fluid Dairy <input type="checkbox"/> No Yogurt <input type="checkbox"/> No Cheese <input type="checkbox"/> Avoid ALL dairy products even in baked goods	<input type="checkbox"/> No Milk <i>(Soy milk will be offered)</i>	<input type="checkbox"/> No Peanut <input type="checkbox"/> No Tree Nut	<input type="checkbox"/> No Corn	<input type="checkbox"/> No Soy	<input type="checkbox"/> No Whole Egg <input type="checkbox"/> No Egg Whites <input type="checkbox"/> No Eggs in baked goods	<input type="checkbox"/> No Wheat	<input type="checkbox"/> No Fish <input type="checkbox"/> 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.