
Guidance for Students with Special Dietary Needs

Date: _____ Dr. _____ Phone Number: _____ Address: _____

If your patient/student has a disability as described in Section 504 of the Rehabilitation Act or Part B of IDEA. The District will honor substitutions.

This form must be signed by a licensed physician or a registered dietitian.

This form needs to be completed only once for a student's record and will be in effect until retracted or changed by the recognized medical authority.

NAME OF STUDENT _____ DOB _____

PARENT'S NAME _____ Phone: Home _____

Parents Signature _____

Work _____ Cell _____ Best time to reach you _____ At which no.? _____

Reason for Dietary Restriction: _____

Restriction: Please check all that apply and give clear direction.

- Lactose intolerance: Omit all dairy _____ Omit fluid milk only _____
- Diabetes: Carbohydrate Count: Breakfast _____g Lunch _____g Snack _____g
- Gluten Free: _____
- Soy: All soy _____ Mg of soy or less allowed _____
- Eggs All eggs _____ (such as baked in a muffin) Just whole egg _____
- Nut allergy: What kind(s) of nuts Tree nuts _____ Peanuts _____ Other _____
How severe is the allergy? Ingesting/eating _____ Skin contact _____ Airborne _____
- Seafood _____
- Other _____

Reason for Texture Modification: _____

Texture Modification: Please check all that apply and give clear direction.

- Puree _____ (ex: applesauce baby food)
- Thickened pureed: foods semi solid blenderized table food with minimal liquid added. (ex: mashed potato, yogurt, pudding)
- Ground Food: _____ Table foods in grinder NO liquids added (ex: hamburger)
- Chopped Foods: _____ Table food cut to approximately 1/4 of an inch.
- Liquid modification: Nectar _____ (ex: tomato juice) Thick _____ Please give specific instruction.

Other instructions _____

Physician's Name: _____ Signature of Physician _____

Serving children with special dietary needs presents our staff with challenges as well as rewards. Thank you for providing needed guidance.

