# SPECIAL DIET FORM 2022-2023

☐New Dietary Request
☐Temporary Diet Order
☐Change Current Dietary Request (start ___________ end_______________)
☐Discontinue Dietary Request

Date: ______________________ School: ______________________
First Name: ______________________ Student ID#: ______________________
Last Name: ______________________ Date of birth: ______________________
Street Address: ______________________ Phone Number: ______________________
City: ______________________ State: ______________ Zip Code: ______________
Parent/Guardian: ______________________ Phone Number: ______________________

**To Be Completed by Licensed Physician/Medical Authority**

Diagnosis ______________________________

Does this child have a disability requiring diet modification? ☐Yes ☐No

If yes, indicate the major life activities and/or bodily functions affected:

☐Eating ☐Caring for Self ☐Walking ☐Hearing ☐Vision ☐Learning ☐Speaking ☐Breathing ☐Performing Manual Tasks

☐Immune function ☐Normal cell growth ☐Digestive ☐Bladder ☐Neurological ☐Respiratory ☐Circulatory ☐Endocrine ☐Cardiovascular

**Diet Order (**Indicate specific restrictions per meal in space provided)

☐Diabetic Breakfast CHO ____g/Lunch CHO _________g/Snack CHO_________g
☐Cardiac Fat ______g/ NA _________g
☐Renal K______g/ NA________g/Phos _______mg
☐Weight Maintenance Fat _____g/Kcal _________
☐Sodium Restriction NA ________g
☐Fat Restriction Fat ________g
☐PKU Protein _______g
☐Other List: ____________________________________________
☐ Formula/Supply
House Formula is Pediasure Yes________ No_______
If no, specify reason___________________

**Food Allergy/intolerance**

☐Lactose Free ☐Peanuts
☐Corn ☐Soy
☐Eggs ☐Wheat
☐Milk ☐Fish
other: ___________________
*Is the allergy life-threatening or severe?
Yes_____ No______
*Are foods containing allergens as ingredients allowed? Yes____ No____
(For example: can consume milk in breads, but not fluid milk)

☐Physical Disability

☐Activities of Daily Living Affected

☐Texture Modification required *(if applicable, specify below)*

**Liquids**

☐Thickened (Nectar)
☐Thickened (Honey)
☐Thickened (Pudding)

**Solids**

☐Mechanical Soft Chopped
☐Mechanical Soft Ground
☐Pureed

Provide additional information as related to diet (may attach additional documents or notes if more space is needed):

______________________________ ______________________________
Prescribing Physician or Medical Authority Name — Prescribing Physician or Medical Authority Signature

Medical Authority Credential
☐ MD ☐ DO ☐ RD ☐ PA ☐ NP

______________________ ______________________
Telephone — Fax

I understand it is my responsibility to renew this form before each school year and anytime my child's medical or health needs change.

______________________ ______________________ ______________________
Parent/Guardian Name — Parent/Guardian Signature — Parent/Guardian Email

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