Special Diet & Medication Form

Per ADE reviewer: Special Diet & Medication Forms should not require form to provide a diagnosis by name. Two highlighted areas are where we need to make the change. Instead of diagnosis replace with "diet restriction"

New Change/Modify Temporary (End Date: _____)

STUDENT INFORMATION

First Name: _____ Last Name: _____ Today's Date: _____

Student ID Number: _____ Age: _____ Male / Female Date of Birth: _____/_____/_____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian Name: _____ Phone/Email: _____

MEDICAL INFORMATION

Per the United States Department of Agriculture, a person with a disability is any such person who has an impairment that substantially limits one or more life activities. By definition this includes but is not limited to diabetes, PKU, celiac disease, food anaphylaxis, learning disabilities, and etc.

THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN ONLY.

Patient Diagnosis/Medical Condition: _____

Is patient diagnosis considered a disability? _____YES _____NO (DR. INITIAL ONLY)

If yes, please describe major life activities affected in relation to dietary modification: _____

_____

Texture Modification: Ground Chopped Pureed Other (please be specific): _____

Tube Feeding: Formula Name: _____ Instructions: _____ Oral? _____YES _____NO

Nutrient Modification: Increase Calories _____ Decrease Calories _____ Nutrient Restriction _____

Omit Foods: _____ Substitute with: _____

Does patient have a life threatening food allergy? _____YES _____NO (DR. INITIAL ONLY)

Food Allergies (circle all that apply):

Fluid Milk All Dairy Products Soy Eggs All Products With Eggs

Wheat Gluten Corn All Corn Additives Seafood

Peanuts All Nuts All Foods Produced in Facility With Nut Products

Can patient consume allergen as an ingredient in food product? _____YES _____NO (DR. INITIAL ONLY)

Administration of Medication at School For Treatment of Allergic Reactions

Allergic Symptoms	Medication	Dosage & Route	Self Carry (DR. INITIAL ONLY)

Physician Name: _____ Phone: (_____)_____-_____

Physician Signature: _____ Date: _____

Any change of treatment must be requested in writing on this form.
Once form is submitted, please allow up to five days for processing. Send completed form to food service department.
By signing below, I understand that it is my responsibility to renew this form anytime my child's medical or health needs change.

Parent Signature: _____ Date: _____