



# Special Diet & Medication Form

🍏 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: \_\_\_\_\_