Health Services
Return Form to Building School Nurse

SPECIAL DIET FORM – NUTRITION SERVICES

Please Return Form to Building School Nurse
(School Nurse Will Forward to Nutrition Services)

Student Name:______________________________ DOB: _________________ Year: ___________
School: ___________________________________Grade:________ Home Room:______________

PART A – Please complete this form if your child requires special meals.
Current information must be submitted at the beginning of each school year

Does the child have a disability as defined in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990? If Yes, describe the major life activities affected by the disability.	**Yes** (Disability)	**No** (Disability)
Does the child have special nutritional or feeding needs? If Yes, have Health Care Provider complete and sign Part B.	**Yes** (Special Nutritional Needs)	**No** (Special Nutritional Needs)
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, please have your Health Care Provider complete and sign Part B.	**Yes** (Medical Reasons–No Disability)	**No** (Medical Reasons–No Disability)
If the child does not have a disability, does the child have special dietary needs? If Yes, please complete Part B and have it signed by the Parent/Legal Guardian.	**Yes** (Religious Reasons–No Disability)	**No** (Religious Reasons–No Disability)

PART B – TO BE COMPLETED BY A PHYSICIAN OR PRESCRIBING HEALTH CARE PROVIDER

Please ☒ check mark any food allergies or intolerances child has and list the foods that are to be omitted & substituted.
Please make notation if it is a SEVERE/LIFE-THREATENING allergy. Note: Beverage substitutions may be limited due to regulations.

MILK ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Milk and uncooked dairy products only
(Ex. Fluid milk, yogurt, cheese, etc.)
❑ Milk, dairy, and ALL milk products (includes cooked & denatured milk products. Ex. Breads, cookies, etc.)
❑ Fluid milk only
❑ Lactose Intolerant

Foods to be omitted: _________________________________
Substitutions: ____

EGG ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Eggs only (Ex. Boiled, scrambled, individualized eggs
❑ Eggs and ALL egg products (This includes cooked and denatured egg products. Ex. Breads, muffins, etc.)

Foods to be omitted: ____
Substitutions: ____

NUT ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Peanuts
❑ Tree nuts
❑ Other

Foods to be omitted: _________________________________
Substitutions: _______________________________________

SOY ALLERGY ❑ SEVERE/LIFE-THREATENING
❑ Soy only (Ex. Soy milk, soy yogurt, etc.)
❑ Soy and ALL soy products (This includes cooked and denatured soy products. Ex. Taco meat, chicken tenders, burger patty, etc.)

Foods to be omitted: ____
Substitutions: ____

OTHER ALLERGIES ❑ SEVERE/LIFE-THREATENING
Foods to be omitted: ____
Substitutions: ____

Do foods need to be modified in texture? If yes, please describe the modifications needed (i.e. chopped, finely ground, pureed, etc.):	**Yes** (Texture Modified)	**No** (Texture Modified)

Additional Dietary Restriction or Special Diet or Comments on child's eating/feeding concerns? Please describe.

Religious Restrictions (Does not need to be completed by a physician or medical authority) Please list foods restricted:

Parent/Guardian Signature	Best Daytime Phone	Date
Physician, or Medical Authority's Signature	Phone	Date

Please have Health Care Provider complete the Medication Authorization Form if medication(s) are ordered.

❑ ***Reviewed by school nurse & forwarded to Nutrition Services on _____________(date) __________________ (School Nurse Signature)***

Revised March 2021