

## DIETARY ORDER FORM

Name of Scholar: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Campus: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis/Disability: \_\_\_\_\_

- (1) Disability: Autism Mental Retardation Orthopedic Impairment Emotional Disturbance Learning Disability  
Traumatic Brain Injury ADHD Other Health Impairment (please list) \_\_\_\_\_

- (2) How does this handicap/disability restrict the child's diet? \_\_\_\_\_

- (3) Major life activity affected by disability: Eating Walking Seeing Hearing Speaking Learning Performing  
Manual Task Breathing

- (4) Diet Prescription:

- Diet Order (specify calories, carbs, sodium, etc.): \_\_\_\_\_
- Foods to omit **due to allergies**: Milk/Dairy Peanut Butter Wheat/Bread Eggs Citric Acid  
Other \_\_\_\_\_
- Food to be substituted: \_\_\_\_\_

Duration of time for special diet/restriction: \_\_\_\_\_ Weeks \_\_\_\_\_ Months. Until end of school year

Textures allowed: (check) Regular Ground Pureed Chopped Other \_\_\_\_\_

I \_\_\_\_\_, (physician) declare the child listed above to possess the following **life threatening food allergy**.

- (1) Life threatening food allergy- Omit these foods:

Fluid Milk Peanuts Tree Nuts Eggs Fish Shellfish Wheat Soy

- (2) Can the student consume foods where the allergen is an ingredient in the food product? (Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed.)

Yes No Explain \_\_\_\_\_

- (3) Other life threatening food allergies (list all)- Omit these foods: \_\_\_\_\_

I certify that the above named child required nutritionally modified meals as described above due to the child's disability.

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

### FOR THE PARENT/GUARDIAN

I give permission for the school staff to follow the above nutrition plan.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

USDA regulations require any substitutions or modifications to school meals for children whose disabilities restrict their diets be supported by a statement signed by a licensed physician. **The physician's statement must identify:** (1) The child's disability and an explanation of why the disability restricts the child's diet; (2) The major life activity affected by the disability; (3) The food or foods to be omitted from the child's diet.

**PLEASE NOTE:** Food allergy or food intolerance is not considered a disability under USDA's non-discrimination regulations unless, in the physician's assessment, the allergy may lead to severe, life-threatening reactions.

Diet prescriptions from Mexico will not be accepted in accordance with USDA Child Nutrition Program regulations.