Alto INDEPENDENT SCHOOL DISTRICT - CHILD NUTRITION

**Phone-936-858-7126** **SPECIAL** **DIET ORDER FORM Fax 936-858-4387**

**To be completed by a recognized medical authority such as a licensed physician, physician’s assistant or nurse practitioner**

|  |  |
| --- | --- |
| Student Name:  | Parent Name:  |
| Birth date:  | Address:  |
| School:  |   |
| Grade:  | Daytime phone:  |
| Teacher:  |   |

Diet modifications for a disability, medical condition, allergy or food intolerance will only be made when the need is certified by a licensed medical authority. This information will be good for 1 school year and will be required to be done yearly.

 **\*Required information**

**\* Child’s disability or diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*describe the major life activity or reactions affected by the disability or diagnosis:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*IS THIS A LIFE THREATENING CONDITION? Circle YES NO**

**\*Does the child require special meals? YES NO**

**\*Student is competent to make appropriate food choices? YES NO \*Please submit a diet plan or complete the following:**

|  |  |
| --- | --- |
| **FOODS TO BE OMITTED**  | **ALLOWABLE SUBSTITUTIONS**  |
|  |  |

**I certify that the above named student needs special school meals as described above, due to the student’s disability or medical condition.**

|  |  |  |
| --- | --- | --- |
| **\*Signature of Authorized Medical Authority**  | **Phone number**  | **Date**  |
| **Signature of Parent**  |  | **Date**  |

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