Weld County School District 6 - Special Dietary Needs Documentation Form

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name:_____

Birthdate:_____

Name of School:_____

Grade/Classroom:_____

Parent/Guardian's Name:_____

Parent/Guardian Telephone:_____

Parent/Guardian Alternate Telephone:_____

"Fueling the Future"

Weld County School District 6
Nutrition Services

TO BE COMPLETED BY THE PROPER RECOGNIZED MEDICAL AUTHORITY
(according to the specifications below for Disability/Handicap vs. Other Special Dietary Need)

This portion of the form must be completed by the appropriate recognized medical authority.

	YES	NO
Does the child have a Disability or Handicap? *If YES, please complete SECTION A below.*		

**If the child does have a Disability or Handicap, this document must be signed by a LICENSED PHYSICIAN (MD or DO).*

A disability is considered a physical or mental impairment which substantially limits one or more major life activity/activities. **Please note that severe food allergies (e.g. life threatening peanut allergies) fall into this category.**

	YES	NO
Does the child require Other Special Dietary Needs? *If YES, please complete SECTION B below.*		

**If the child has Other Special Dietary Needs, this document must be signed by a LICENSED PHYSICIAN (MD or DO), PHYSICIAN'S ASSISTANT (PA), or ADVANCED REGISTERED NURSE PRACTITIONER (ARNP).*

Other special dietary needs are most often related to food allergies (that are non-life threatening) and food intolerances.

SECTION A - For Disabilities/Handicaps

Indicate **Life Threatening** Allergy:_____

List Food(s) to be Omitted:_____

List Food(s) to be Substituted:_____

OR

Indicate Disability/Handicap:_____

List Major Life Activities Affected:_____

Is Modified Texture Required?	YES	NO	
If YES, Indicate Texture:	CHOPPED	GROUND	PUREED
Are Thickened Liquids Required?	YES	NO	
If YES, Indicate Consistency:	NECTAR	HONEY	PUDDING

SECTION B - For Other Special Dietary Needs

Indicate Diet Restrictions and/or Special Dietary Needs:_____

List Food Allergy/Intolerance:_____

List Food(s) to be Omitted:_____

List Food(s) to be Substituted:_____

ADDITIONAL INFORMATION/COMMENTS:

_____

_____

_____

I certify that the above named student needs special school meals as described above, due to the student's disability or other special dietary need.

RECOGNIZED MEDICAL AUTHORITY PRINTED NAME: _____ **DATE:** _____

RECOGNIZED MEDICAL AUTHORITY SIGNATURE: _____ **TELEPHONE NUMBER:** _____

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

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

**It is strongly recommended that medical authorities annually update the prescribed diet order.*

8/5/2013