DONNA CHILD NURTRITION PROGRAM
DIETARY ORDER FORM

Student's Name: _____Date of Birth: _____

Campus: _____Grade: _____

School Nurse: _____ School Year: _____

Diagnosis/Disability: _____

(1) Disability: Autism- Mental Retardation- Orthopedic Impairment -Emotional Disturbance Learning Disability - Traumatic Brain Injury – ADD - Other Health Impairments

_____

(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-Manuel Task- Breathing

(4) Diet Prescription:

- Meal Plan: 1200Kcal-1500Kcal-200Kcal- Low Fat- Other_____
- Foods to omit **due to allergies**: Milk Dairy- Peanut Butter-Wheat/Bread-Eggs-Citric Acid-Other:_____
- Food to Substituted: Lactaid Milk- Soy Milk-Other

Duration of time for special diet/restriction: ____ Weeks _____ Months _____ until for remainder of School Year.

Textures allowed: (Check) Regular- Ground- Pureed Chopped- Other_____
I certify that the above named child requires nutritionally modified meals as described above due to the child's disability.

_____ _____
Signature of U .S. Licensed Physician Date

_____ _____
Printed Name of Physician Date

Parent/Guardian: I give permission for the school staff to follow the above nutrition plan.

Parent/Guardian Signature: _____

USDA regulations require any substitutions or modifications in 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 & 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 prescription from Mexico will NOT be accepted in accordance with USDA child Nutrition Program regulations.

Return complete form to School Nurse

YEARLY RENEWAL REQUIRED

For CNP Staff only

Received: _____ Date: _____ Order modified: _____

Faxed: _____ D/C Order: _____