

Special Dietary Request Form for Students

Date _____

School Name Welch Elementary School

School Year _____

Student Name _____

Student Age _____

Grade Level _____

Homeroom Teacher _____

Does the Student have a medical disability? Yes No (If no, see OTHER DIETARY REQUEST below. If Yes, complete the form and have it signed by a physician.)

Name medical disability for which the specialized diet is required (e.g., PKU, Diabetes types 1 or 2, Cerebral Palsy):

Describe the major life activities affected by the disability: _____

List any dietary restrictions or special diet (e.g. low protein, no wheat, carbohydrate counting, texture modifications):

List any threatening anaphylactic food allergies (e.g., peanut allergy): _____

List any supplemental feedings required (e.g., snacks, frequency, AM and/or PM): _____

If a student has diabetes, at what blood sugar level should hypoglycemia be treated, and what are the preferred glucose sources(s) for treatment: _____

List foods that need to be changed in texture if all foods need to be prepared in this manner indicate, "all":

Cut up or chopped to bite-size pieces _____ Finely ground _____ Pureed _____

List special equipment or feeding utensils needed: _____

Physician's Signature _____ Date _____

Procedure continued as prescribed until: _____

Other Dietary Request

If a student does not have a medical disability but has a special nutritional or feeding request, it is optional for the school to comply with the request.

Please state the special nutritional need: _____ and clearly state foods to avoid or those to be substituted; e.g., lactose reduced milk for lactose intolerance:

A dietary request requires the signature of an RN, an RD, a Family Nurse Practitioner, or a Physician's Assistant

Signature _____ Date _____

Manager's Approval: Yes No

School Health Nurse Signature _____ Date _____

School Nutrition Program Manager _____ Date _____