SPECIAL DIET PLAN

PART 1: STUDENT INFORMATION
PARENT OR GUARDIAN MUST COMPLETE. PLEASE PRINT.

Student's Name: Last / First / Middle Initial	Date of Birth:

Parent/Guardian Name:	WORK / HOME / CELL PHONE NUMBERS

Name of School/Site:	

Meals or snacks to be eaten at school/center/site: (circle all that apply)

Breakfast Lunch snack

PART 2: STUDENT STATUS
LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT.

Section A:

☐ **Student has a disability and requires a special diet or food accommodation.** An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the American with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits one or more major life activities.

Identify the Student's disability:_____ AND/OR

Identify the Food allergy that is life-threatening/ anaphylactic reaction. (considered a disability): _____

_____

☐ Has Epi pen _____

Section B:

☐ **Student does not have a disability but is requesting a special meal or dietary accommodation.**

☐ **Lactose Intolerance:** ☐ No milk to drink (Schools offer lactose-reduced or lactose-free milk as required by state law) Please specify:

_____

☐ **Food Intolerance:** Food(s) intolerant to: _____

_____

☐ **Food Allergy:** Food(s) allergic to: _____

_____

The student's allergy to the food(s) stated above **does not** result in a life threatening (anaphylactic) reaction.
PLEASE NOTE: a food allergy **is** considered to be a disability when it results in a life-threatening (anaphylactic) reaction.

PART 3: DIETARY ACCOMMODATION FOODS TO BE ALLOWED AND FOOD TO BE OMITTED
LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT

♦The school cannot guarantee that the facility or dining area will be allergen free.♦

List specific foods to be omitted. You may attach a sheet with additional information.

Category	FOODS ALLOWED	FOODS OMITTED
Bread/ Grain		
Milk		
Fruit /Vegetables		
Meat/Meat Alterative		
Other		

☐ **Texture Modification:** _____Pureed _____Ground _____Bite-Sized Pieces _____Other (specify) _____

_____

☐ **Other Dietary Modification OR Additional Instructions Please include any restricted meal patterns** (describe):

_____

_____

(attach *specific diet order instructions)*

SIGNATURE OF LICENSED PHYSICIAN

Licensed Physician/Physician's Assistant/ Nurse Practitioner

Name/Credentials **(print):** _____

Signature:_____ Date: _____

Clinic Name: _____

Phone #: _____ Fax #:_____

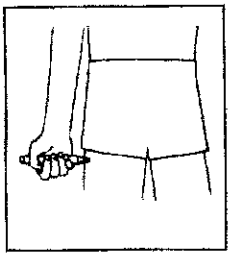
If your child has food allergies or has special dietary need, please take this form to your doctor's office.
This form must be completed and returned for your child to be eligible for a special diet program

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone: _____ 2. _____ Relation: _____ Phone: _____ 3. _____ Relation: _____ Phone: _____	1. _____ Room _____ 2. _____ Room _____ 3. _____ Room _____

EpiPen® and EpiPen Jr® Directions

1. Pull off gray safety cap

2.



Place black tip on outer thigh (always apply to thigh)

3. Using a quick motion, press hard into thigh intil Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.

7/23/12 sjz