CARTERSVILLE CITY SCHOOLS

Special Dietary Request Form for Students

Student's Name:_____Date:_____

School _____Student's DOB:_____Grade Level:_____Classroom:_____

TO BE COMPLETED BY PHYSICIAN OR MEDICAL AUTHORITY

DISABILITY DIETARY REQUEST

Does the student have a medical disability which requires special dietary consideration ?___Yes___No.

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 life threatening anaphylactic food allergies; e.g., peanut allergy_____

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

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:_____

Licensed Physician's Signature:_____

Date:_____

School Nutrition Manager's Signature:_____Date:_____

School Nutrition Manager's Approval: Yes___No___

School Health Nurse Signature:_____Date:_____

School Administrator's Signature:_____Date:_____

White copy – School Nutrition Manager
Yellow copy – School Nurse
Pink copy - Parent