SPECIAL DIETARY ORDER FORM   SCHOOL YEAR ____________________

(Please Print All Information)

Student's Legal Name (First, MI, Last): ____

Grade Level: ___________

Medical Diagnosis or Disability: ____

Describe the student's condition for this dietary order: ______________________________

____

Physicians Name: ____________________________ Phone #: ______________________

Is the Medication on school campus? Yes ___ No ___   Location: _______________________

FOOD INTOLERANCES

Does the student have a food intolerance? Yes ____ No ____

List the MEDICATION: ____

Does the student know how to administer his/her medication? Yes ___ No ___

Please list the food or foods to avoid: ____

____

FOOD ALLERGY

Does the student have a food allergy? Yes ___ No ____

If yes, does the student need MEDICATION? Yes ___ No ___

List the MEDICATION: ____

____

Does the student know how to administer his/her medication? Yes ___ No ___

Please list the food or foods to avoid: ____

____

Parent's Name ____

Emergency contact numbers: ____

Parent's Name

____

Emergency contact numbers: ____

Parent Signature ___________________________________ Date ___________________