DIOCESE OF ALEXANDRIA

Allergy/Food Restrictions Form

Student's Name

Age

School

Grade/Classroom

Parent's Name

Address

(Street or P. O. Box)

City

State

Telephone


Does the student have a disability that requires a special diet modification?

Yes ______ No ______

Diet Prescription (Check all that apply):

____ Diabetic

____ Food Allergy

____ Hypoglycemic

____ Other

Foods Omitted and Substitutions: Please identify specific foods to omit and list foods to be substituted. (i.e. Omit milk and substitute juice)

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<th>Specific Foods to Omit</th>
<th>Specific Foods to Substitute</th>
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I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

Office Address

Office Telephone # ( )

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1Licensed Physician/Recognized Medical Authority Signature

Date

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DIOCESE OF ALEXANDRIA
CHILD NUTRITION PROGRAM
DIET PRESCRIPTION FOR MEALS AT SCHOOL
*Return completed form to cafeteria manager*

Patient Information

Student’s Name__________________________________________ Age____
School____________________________________________________ Grade____
Parent’s Name____________________________________________
Mailing Address___________________________________________
City______________________________________________________ State____________
Telephone (_____)______________________

Disability
Does the student have a disability that requires a special diet? Yes______ No______
If yes, describe the major life activities affected by the disability. _______________________________
(See attached Bulletin 1196 Section 727 for further information.)

Medical Condition
If the student is not disabled, check the medical condition that requires special nutritional or feeding needs.
(Check all that apply):

( ) Diabetic ( ) Increased Calorie ________________#kcal
( ) Food Allergy ( ) Reduced Calorie ________________#kcal
( ) Hypoglycemic ( ) Texture Modification
-Chopped____-Ground____-
( ) PKU ( ) Pureed____-Liquefied____-
( ) Other_______________ ( ) Tube Feeding
-Liquefied Meal_____Formula____-

Foods To Be Omitted and Substitutions
Check the food groups to be omitted. Identify specific foods to omit and list foods to be substituted. If necessary, attach additional information or instructions regarding the diet or feeding.

Food Groups to Omit: ( ) Meat and Meat Alternatives ( ) Milk and Milk Products
( ) Fruits and Vegetables ( ) Bread and Cereal Products

Specific Foods to Omit
__________________________________________________________

Specific Foods to Substitute
__________________________________________________________

I certify that the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

______________________________ ( ____ ) ______________________
Office Address Office Telephone #

Licensed Physician/Recognized Medical Authority Signature Date

*Signature of Licensed Physician required if student is disabled.*
**Definition of Disability**

**Definitions**

As used in this part, the term or phrase:

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**Student with disabilities** means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

**Physical or mental impairment** means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term *physical or mental impairment* includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism.

**Major life activities** means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

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