Greeley-Evans Weld County School District 6 - Special Dietary Needs Documentation Form

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name:______________________________

Student's School ID Number:______________________________

Birthdate:______________________________

Name of School:______________________________

Grade/Classroom:______________________________

Parent/Guardian's Name:______________________________

Parent/Guardian Telephone:______________________________

Parent/Guardian Alternate Telephone:______________________________

This portion of the form must be completed by the appropriate recognized medical authority.

TO BE COMPLETED BY THE PROPER RECOGNIZED MEDICAL AUTHORITY (according to the specifications below for Disability/Handicap vs. Other Special Dietary Need)

Does the child have a Disability or Handicap? YES NO
If YES, please complete SECTION A below.

*If has a Disability/Handicap, this document must be signed by a LICENSED PHYSICIAN, ADVANCED PRACTICE NURSE with prescriptive authority or PHYSICIAN'S ASSISTANT.

A disability is considered a physical or mental impairment which substantially limits one or more major life activity/activities. **Please note that severe food allergies (e.g. life threatening peanut allergies) fall into this category.**

Does the child require Other Special Dietary Needs? YES NO
If YES, please complete SECTION B below.

*If the child has Other Special Dietary Needs, this document must be signed by a LICENSED PHYSICIAN, ADVANCED PRACTICE NURSE or PHYSICIAN'S ASSISTANT.

Other special dietary needs are most often related to food allergies (that are non-life threatening) and food intolerances.

SECTION A - For Disabilities/Handicaps

Indicate **Life Threatening** Allergy:______________________________

List Food(s) to be Omitted:______________________________

List Food(s) to be Substituted:______________________________

OR

Indicate Disability/Handicap:______________________________

List Major Life Activities Affected:______________________________

Is Modified Texture Required?	YES	NO	
If YES, Indicate Texture:	CHOPPED	GROUND	PUREED
Are Thickened Liquids Required?	YES	NO	
If YES, Indicate Consistency:	NECTAR	HONEY	PUDDING

SECTION B - For Other Special Dietary Needs

Indicate Diet Restrictions and/or Special Dietary Needs:______________________________

List Food Allergy/Intolerance:______________________________

List Food(s) to be Omitted:______________________________

List Food(s) to be Substituted:______________________________

ADDITIONAL INFORMATION/COMMENTS:

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I certify that the above named student needs special school meals as described above, due to the student's disability or other special dietary need.

RECOGNIZED MEDICAL AUTHORITY PRINTED NAME: ______________________________ **DATE:** ______________

RECOGNIZED MEDICAL AUTHORITY SIGNATURE: ______________________________ **TELEPHONE NUMBER:** ______________

I hereby give permission for the school staff to follow the above stated nutrition plan.

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________

*It is strongly recommended that medical authorities annually update the prescribed diet order.

8/1/2022