STUDENTS NAME:	AGE:
SCHOOL ATTENDING	**GRADE:**
DOES YOUR CHILD HAVE AN EATING DISABILITY OR FOOD ALLERGY?	**YES OR NO**
If yes, please describe the major life activities that are affected by the disability.	
DOES YOUR CHILD HAVE SPECIAL NUTRITIONAL OR FEEDING NEEDS?	**YES OR NO**
If yes, please describe below, then complete this form and have it signed by a licensed physician.	
IF THE CHILD DOES NOT REQUIRE SPECIAL MEALS, THE PARENT CAN SIGN AT THE BOTTOM AND RETURN THE FORM TO THE SCHOOL FOOD SERVICE.	

List any dietary restrictions or special diet:

_____

_____

List any allergies or food intolerance to avoid:

_____

_____

List foods to be substituted:

_____

_____

List foods that need the following change in texture. If all foods need to be prepared in this manner , please indicate "ALL"

Cut up or chopped into bite size pieces: _____

Finely ground: _____

Pureed: _____

List any special equipment or utensils that are needed:

_____

PARENT OR GUARDIAN SIGNATURE:	**DATE**
PHYSICIAN OR MEDICAL AUTHORITY'S SIGNATURE	**DATE**