ECSD Diet Prescription for Food Restrictions /Substitutions

This form MUST be completed and signed by a Physician if your child requires a dietary restriction (i.e. no peanut butter, no strawberries, etc.) OR a food substitute (i.e. allergic to cow's milk – substitute soy milk).

This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.)

It must also be completed and signed by a Physician to reverse a previous accommodation (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction"

IF STUDENT DOES NOT REQUIRE SPECIAL MEALS (RESTRICTIONS AND/OR SUBSTITUTIONS) THE PARENT/GUARDIAN CAN SIGN AT THE BOTTOM OF THIS FORM AND RETURN THE FORM TO THE OFFICE

PART A

Name of Student:		**Date of Birth:_____/_____/_____**	
Allergies/reaction:			
Name of School:	**Grade:**	**Classroom:**	
PHYSICIAN			
Does student have a Life-Threatening food allergy? ***If yes, a Life-Threatening Food Allergy Care Plan must be completed and signed by the parent and physician.**		☐ **Yes**	☐ **No**
Does the student have other special nutritional or feeding needs that require a food substitution or special diet? ☐ **Intolerance /Sensitivity** ☐ **Religious/cultural practices** ☐ **Texture/swallowing concerns/Thickeners**		☐ **Yes**	☐ **No**

List specific life threatening food allergies:

List specific non- life threatening food sensitivities/intolerance:

List specific foods to avoid/omit (detailed foods please, especially dairy products):

List foods to be substituted:

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

Thickener (please provide detailed instruction):

Cut up or chopped into bite-size pieces:

Finely ground:

Pureed:

List any special equipment or utensils that are needed:

Indicate any other comments about student's eating or feeding patterns:

Last Swallow Study Date:	**Pass/Fail**	***Please attach results**

Physician's Signature: _____ **Print or Stamp:**	**Date:_____/_____/_____**

This form is good for one school year. Parent please fill out other side.

PARENT:

- ❑ MY CHILD REQUIRES A FOOD RESTRICTION/ FOOD SUBSTITUTION AND DIETARY MONITORING.
- ❑ MY CHILD DOES NOT REQUIRE A FOOD RESTRICTION OR SUBSTITUTION. THERE IS NO NEED FOR DIETARY MONITORING BY ANY ELYRIA SCHOOL EMPLOYEE OF THOSE CONTRACTED FOR SERVICES.

Date:_____/_____/ _____

Parent/Guardian's Signature: _____

SECRETARY: For School Use Only—Copy to be filed in RN Review File and Student Health File; Scanned to HOMEROOM TEACHER, FOOD SERVICES and SCVIEW IMMEDIATELY.

Copy Sent to: [ ]RN: Health Services [ ] Student Health File [ ] Food Services

[ ] SCVIEW [ ] Homeroom Teacher

Reviewed by:_____Date:_____

Reviewed by:_____Date:_____

Reviewed by:_____Date:_____

Reviewed by:_____Date:_____

Reviewed by:_____Date:_____

Reviewed by:_____Date:_____

Reviewed by:_____Date:_____

Physician diagnosed disability/special need [ ] Has IEP or 504 [ ] Needs IEP or 504 Evaluation

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NOTE: If emergency medication is needed for your student's allergic response, this medication must be brought to school, along with a physician's order and parental authorization. An emergency care plan must be written with the School Nurse.

Parent Signature: _____ **Date:** _____

I _____ **Do Not want** my child _____ with a nut allergy to sit at a separate designated "Nut Free" table at lunch.

I _____ **Do want** my child _____ with a nut allergy, to sit at the designated "Nut Free" table at lunch.

_____

Parent Signature

_____

Physician Signature

This form is good for one school year. Parent please fill out other side.