# CHARLOTTE COUNTY PUBLIC SCHOOL

# SPECIAL DIETARY NEEDS INFORMATION CARD

# Instructions: This form should only be completed by a physician if the student has special dietary needs.

#  \* indicates must be completed

|  |  |
| --- | --- |
| \* Student's Name | Teacher's Name |
| \*Special Diet or Dietary Restrictions- Please be specific |
| \*Food Allergies or Intolerances- Please be specific |
| \*Allowable Food substitutions - Please be specific |
| Foods Requiring Texture Modifications:Chopped:Finely ground:Puree or Blended: |
| Other dietary modifications: |
| Feeding techniques |
| Supplemental Feedings |
|  \*Medical or Medical Authority: Please Print Name: Telephone: Fax:Phone: Fax: |
|  |  |
|  |  |
| \*Signature of doctor or medical authority | \*Date |
|  |  |
| **Office use only:**Date received by School Food Service Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of The School Food Service Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\_\_\_\_\_ NO, my child has no special dietary needs.**

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 Parent Signature Date