Nekoosa School District
____School Year
Clinician Order for Diet Modification
For Child Identified with Special Health Care Needs

Student Name: _____ DOB: ___/__/___ Grade: ___ Class: _____
Parent: _____ Home phone: _____ Cell # _____
Clinician _____ Clinic _____ Clinic Phone: _____

Medical reason for diet modification: _____

This form should be completed for a student needing diet modification at school. Complete this form even if it is not expected that the child will eat school breakfast or lunch. Use this form if the child has:

- Food allergies
- Diet modifications due to health conditions
- Diet modifications for food alteration such as texture, fluid requirements or tube feedings
- A change in diet needs
- A need for special diet equipment

I will notify the school in writing of any changes in my student's dietary needs. Changes in diet modifications will require a new clinician's signature.

Parent Signature: _____ Date: ___/___/___

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Foods to be omitted:

Foods to be substituted:

Modifications in texture or consistency:

Adaptive equipment needs:

Additional precautions (example choking, feeding position):

Clinician Signature:_____ Date: ___/___/___

Reference: USDA Food and Nutrition Services Instruction 783-2 (Rev-2)