Special Diet Request		
Name of Child		Age
Name of Parent and Guardian		Contact Number
Check one Box	☐	Child has a <u>disability</u> which requires a special meal or accommodation. (Refer to definitions on reverse side of this form). A *licensed medical physician* must sign this form. *Describe
	☐	Child <u>does not have a disability,</u> but a special meal or accommodation due to food intolerance(s) or other medical reasons is requested. A *licensed medical physician, physician's assistant, registered nurse, nurse practitioner, or registered dietitian* must sign this form. *Do not complete this question.
Disability or medical condition requiring a special meal accommodation		
*If child has a disability, describe major life activity affected by the disability.		
Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation, include required food texture if needed.)		
Specific foods to be omitted and substituted. You may attach a sheet with additional information.		
A. Foods to Omit	B Foods to Substitute	
I certify the above named child needs special meals prepared as described above.		
Signature of Medical Authority and Credentials Print Name	Office Phone	Date
Signature of Institution's Authorized representative		
This institution is an equal opportunity provider		