HUDSON INDEPENDENT SCHOOL DISTRICT - CHILD NUTRITION

Instructions: Complete and return if a SPECIAL Diet is necessary for student.

PHONE 936-875-9217

SPECIAL DIET ORDER FORM

FAX 936-875-9316

To be completed by a recognized medical authority such as a licensed physician, physician's assistant or nurse practitioner

Student Name:	Parent Name:
Birth date:	Address:
School:	
Grade:	Daytime phone:
Teacher:	

Meals required: __ Breakfast __Lunch

Diet modifications for a disability, medical condition, allergy or food intolerance will only be made when the need is certified by a licensed medical authority. When diet modifications are implemented by the school, they will continue until a medical authority specifies that they should be changed or stopped. ***Required information**

*** Child's disability or diagnosis ____**

***describe the major life activity or reactions affected by the disability or diagnosis:**

____

*IS THIS A LIFE THREATENING CONDITION? Circle YES NO

***Does the child require special meals? YES NO**

***Student is competent to make appropriate food choices? YES NO**

***Please submit a diet plan or complete the following:**

FOODS TO BE OMITTED	ALLOWABLE SUBSTITUTIONS

I certify that the above named student needs special school meals as described above, due to the student's disability or medical condition.

*Signature of Authorized Medical Authority	Phone number	Date
Signature of Parent		Date

This Institution is an Equal Opportunity Provider.