Children with special dietary needs: Disability or Life-threatening allergy

PART A					
Child's Name	DOB		Date		
School	Grade		Classroom		
Does this child have a life-threatening allergy or disability? If yes, describe the reaction or major life activities affected.				Yes	No
Does the child have special nutritional or feeding needs? If yes, complete Part B of this form and have it signed by a licensed healthcare specialist (Physician, Nurse Practioner, Physician Assistant).				Yes	No
If the child does not require spand return it to the school.	pecial nutritional or feedi	ng needs,	the parent can sign the bottom of this form		
			censed Healthcare Provider)		
List any dietary restrictions or special diet. Please be specific.					
List any food life-threatening food allergies.					
List any food to be substituted	<u>.</u> I.				
List foods that need the following change in texture. If all foods need to be prepared in the manner, indicate "All".					
Cut-up or chopped into bite size pieces:					
Finely ground:					
Pureed:					
List any special equipment or	utensils that are needed.				
Indicate any other comments a	about the child's eating o	r feeding	that are pertinent to school.		
Signature of Licensed Healthcare Provider Date					
Please return form to		From			_ _
Jackie Hess			ame of Health Care Provider		
Bellevue City Schools, Food Servi 125 North Street	vices	Address			
Bellevue, OH 44811		City, State	e ZIP		
Phone: 419-484-5190 Fax: 419-484-5016		Date			
Parent Signature: Date:					
Reviewed by: Date: Date:					

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