

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 Practitioner, Physician Assistant).		Yes No
If the child does not require special nutritional or feeding needs, the parent can sign the bottom of this form and return it to the school.		

PART B (to be completed by Licensed 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.
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 about the child's eating or feeding that are pertinent to school.

Signature of Licensed Healthcare Provider _____ **Date** _____

Please return form to	From
Jackie Hess Bellevue City Schools, Food Services	Printed Name of Health Care Provider
125 North Street	Address
Bellevue, OH 44811	City, State ZIP
Phone: 419-484-5190 Fax: 419-484-5016	Date

Parent Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____
 _____ **Date:** _____

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