

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: ____/____/____

Clinician Order for Diet Modification

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: ____/____/____