



Send completed form to:
 Caldwell County Schools
 Child Nutrition Program, Supervisor/Dietitian
 1914 Hickory Blvd.
 Lenoir, NC 28645
 Phone: (828) 728-8407

DIET ORDER
Annual Medical Statement for Students
with Special Nutritional Needs

Part I (to be filled out completely by parent or guardian)

Name of Student (Last) _____ (First) _____ (MI) _____

Date of Birth ____/____/____ Age _____ Student ID # _____

School Attended by Student _____ Grade: ____ School Year: 20____ to 20____

Will student eat Breakfast at School? Yes, No; Lunch at School? Yes, No

Is student in Before School Program? Yes, No; After School Program? Yes, No

Parent/Guardian's

Phone Number (s) () _____ - _____ (H), () _____ - _____ (W), () _____ - _____ (Cell)

Name of Parent/Guardian _____ Signature _____

Mailing Address _____ City _____ State _____ Zip _____

Part II (to be filled out only by a Licensed Medical Doctor (MD) or Registered Dietitian (RD) treating the student)

Required

Student's Diagnosis

MD Indicate which dietary modification the patient needs and **specify** what changes need to be made for **school meals**:

Texture Modification: pureed ground chopped other _____

Nutrient Modification: (cholesterol, sodium, gluten, etc.): _____

Lactose Intolerance: No milk to drink, Avoid all dairy products, Juice in place of milk @ meals

Diabetes (Please indicate grams of carbohydrate at breakfast and lunch.) _____

Food Allergies: Please check appropriate box(es): ingestion contact inhalation

List foods to be

avoided: _____

MD name (please print) _____

MD Signature _____

Phone _____ Date _____

OR

RD name (please print) _____

RD Signature _____

Phone _____ Date _____

Medical Office Stamp:

Part III Child Nutrition to complete:

CCS Child Nutrition Program Notes:

CCS Dietitian's Signature _____ Date _____

Caldwell County Schools – Child Nutrition Program Diet Order Instructions

Information provided on this form will be used by Child Nutrition personnel to prepare and serve the student's special diet. Information will not be released except to those responsible for the student's meals.

PURPOSE: To record the student's condition requiring dietary modifications of school meals and the changes needed. **This form must be completed at the start of each school year and whenever diagnosis or change is indicated. Annual completion of this form by the child's Medical Doctor (MD) or Registered Dietitian (RD) ensures that current nutritional needs are being met.**

PREPARATION: The parent or guardian of the child is responsible for obtaining the form, filling out Part I, requesting completion by the student's physician or dietitian, and delivering the form to the Child Nutrition office. A licensed physician or registered dietitian is **required to complete** Part II of the document based on the child's medical condition.

INSTRUCTIONS:

Part I (to be filled out by parent or guardian):

Name of Student: Enter the student's last name, first name and middle initial.

Date of Birth: Enter the student's date of birth, e.g. May 1, 1988 or 05-01-88.

Age and Student ID#: Enter the student's current age and Student ID #.

School Attended by Student: Enter the name of the school, which the student regularly attends, grade, school year and indicate if child eats Breakfast and or lunch in school cafeteria.

Parent/Guardian's Phone Number(s): If available, enter one or two telephone numbers (include area codes) where a parent/guardian can be reached during the day: home, work, cell, and mailing address.

Name of Parent/Guardian(s): Print the full name of the student's parent(s) or legal guardian(s).

Signature of Parent/Guardian: Enter the signature of one parent or legal guardian's name. The printed name on the previous line must correspond to the signature.

Part II (to be filled out by Physician (MD) or Registered Dietitian (RD) treating the student):

Student's Diagnosis: Insert the patient's clinical diagnosis for the condition, which requires dietary modification.

Indicate which dietary modification the patient needs and specify what changes need to be made: Check the type(s) of modification the patient's condition requires and fill in the corresponding specifics next to the type of modification. A dietitian can assist in completing this section.

Registered Dietitian's (RD): Provide a **local** dietitian's name and phone number if available.

Registered Dietitian's Signature: Enter the signature of registered dietitian completing the form.

Physician Name, Phone Number and Signature: Enter the signature of the local physician filling out the form and the date signed. Please include Medical Office Stamp.

Part III (to be filled out by Child Nutrition Supervisor/Dietitian)