

# Bibb County School System

## DIET ORDER FORM For Students with Special Nutritional Needs

**RETURN TO DISTRICT REGISTERED DIETITIAN DALIA KINSEY**  
**DALIA.KINSEY@BCSDK12.NET**

### Part I: Completed by Parent or Guardian—Please PRINT

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 / After School Program?  Yes  No

Name of Parent/Guardian \_\_\_\_\_ Signature \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent /Guardian's Phone Number(s): ( ) \_\_\_\_\_ - \_\_\_\_\_, ( ) \_\_\_\_\_ - \_\_\_\_\_, ( ) \_\_\_\_\_ - \_\_\_\_\_,  
Email: \_\_\_\_\_ **Home Work Cell**

### Part II: Completed by Licensed Medical Doctor (MD) treating student—Please PRINT

Student's Disability/Diagnosis: \_\_\_\_\_  
Explanation of why Disability/Diagnosis restricts the student's diet: \_\_\_\_\_

Major Life activity affected by the Disability/Diagnosis: \_\_\_\_\_

### Diet Prescription

**R  
E  
Q  
U  
I  
R  
E  
D**

**MD indicates which dietary modification the patient needs and specifies what changes need to be made. Check  all that Apply:**

**Texture Modification:**  Puree  Ground  Chopped  Modified Thickness of Liquids  
 Other \_\_\_\_\_

**Nutrient Modification:** (cholesterol, sodium, gluten, etc): \_\_\_\_\_

**Lactose Intolerance:**  No milk to drink  Avoid all dairy products

**Diabetic** (Please indicate grams of CHO at breakfast, lunch and snack)

Breakfast \_\_\_\_ Lunch \_\_\_\_ Snack AM \_\_\_\_ Snack PM \_\_\_\_

**Food Allergies:**  ingestion  contact  inhalation

**List foods to be omitted or avoided:** \_\_\_\_\_

**List foods that may be used to substitute foods that must be omitted or avoided:** \_\_\_\_\_

**MD Name:** \_\_\_\_\_

**MD Signature:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Office Stamp**

### Part III: Completed by School Food Service Personnel

**Date SN Mgr. Received:** \_\_\_\_\_ **SN Mgr. Initials:** \_\_\_\_\_

**Date SN Office Received:** \_\_\_\_\_ **SN Office Initials:** \_\_\_\_\_

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint write USDA Director, Office of Adjudication, 1400 Independence Ave., SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or who have speech disabilities may contact USDA through Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.