



**Grand Prairie ISD 2016-2017
Annual Special Diet & Medication**



New Change/Modify Temporary (End Date: _____)

STUDENT INFORMATION

First Name: _____ Last Name: _____ Today's Date: _____
 Student ID Number: _____ Age: _____ Male / Female Date of Birth: ____/____/____
 School: _____ Grade: _____ Teacher: _____
 Parent/Guardian Name: _____ Phone/Email: _____

MEDICAL INFORMATION

Per the United States Department of Agriculture, a person with a disability is any such person who has an impairment that substantially limits one or more life activities. By definition this includes but is not limited to diabetes, PKU, celiac disease, food anaphylaxis, learning disabilities, and etc.

THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN ONLY.

Patient Diagnosis/Medical Condition: _____

Is patient diagnosis considered a disability? YES NO (DR. INITIAL ONLY)

If yes, please describe major life activities affected in relation to dietary modification: _____

Texture Modification: Ground Chopped Pureed Other (please be specific): _____

Tube Feeding: Formula Name: _____ Instructions: _____ Oral? YES NO

Nutrient Modification: Increase Calories _____ Decrease Calories _____ Nutrient Restriction _____

Omit Foods: _____ Substitute with: _____

Does patient have a life threatening food allergy? YES NO (DR. INITIAL ONLY)

Food Allergies (circle all that apply):

Fluid Milk All Dairy Products Soy Eggs All Products with Eggs

Wheat Gluten Corn All Corn Additives Seafood

Peanuts All Nuts All Foods Produced in Facility with Nut Products

Which allergens can the patient consumer as ingredients in food? (please be specific) _____

Administration of Medication at School for Treatment of Allergic Reactions

Allergic Symptoms	Medication	Dosage & Route	Self-Carry (DR. INITIAL ONLY)

Physician Name: _____ Phone: (____) _____

Physician Signature: _____ Date: _____

Any change of treatment must be requested in writing on this form.
 Once form is submitted, please allow up to five days for processing. Send completed form to food service department.
 By signing below, I understand that it is my responsibility to renew this form anytime my child's medical or health needs change.

Parent Signature: _____ Date: _____