

**FNS DIET ORDER for Special Nutritional Needs**  
**Annual Medical Statement for Students**

Date: \_\_\_\_\_

<b>Parent/Guardian: Complete Items 1 – 7 (Pader/tutor: Compleata cajitas 1-6)</b>			
<b>1) Student's Last Name</b> (Apellido)	<b>First Name</b> (Nombre del estudiante)	<b>3) Date of Birth</b> (Fecha de nacimiento)  Age _____	<b>4) Circle Meals Eaten at School</b> (Circule las comidas que su nino/a come en la escuela) <b>Breakfast Lunch Snack</b> (Desayuno) (Amuerzo) (Bocadillo)
<b>5) Parent/Guardian Signature</b> (Firma del Padres/Tutor)	<b>6) Print Name of Parent/Guardian</b> (Escriba en letra de molde el nombre del padre/Tutor)	<b>7) Parent Phone Number(s)</b> (Numero(s) de telefono del padres) Home (Casa): ( ) _____ Cell (Celular): ( ) _____ Night Phone #: ( ) _____	
<b>Mailing Address:</b>			
<b>School Attended by Student</b>		<b>Grade:</b>	<b>School Year: 20 to 20</b>
<b>Cafeteria Manager: Complete Items 8 - 15</b>			
<b>8) School Name</b> (Include EEC name, if applicable)  First State Montessori Academy		<b>9) Site Type:</b> Satellite	
<b>10) School Nurse:</b> Upper School: Becky Adeleke Lower School: Laurie Murray	<b>11) School Nurses' Phone #</b>  (302) 576-1500	<b>12) School Fax #</b>  (302) 576-1501	
<b>13) Cafeteria Manager (C.M.)</b>  Becky Adeleke	<b>14) C.M. Email Address</b>  <a href="mailto:rebecca.adeleke@fsma.k12.de.us">rebecca.adeleke@fsma.k12.de.us</a>	<b>15) Cafeteria Phone #</b>  (302) 576-1500	

Is there an IEP in place at the school that includes dietary restrictions? \_\_\_YES \_\_\_NO

<b>Physician ONLY: Complete Items 16 - 27</b>	
<b>16) Does the student have a disability, medical condition or severe food allergy warranting a special diet?</b>	
<p><u>The disability or medical condition must limit a major life activity such as breathing or learning, and the food allergy must result in a reaction that is life-threatening and/or severely impacts the student's ability to function in school.</u></p> <p><b>YES</b> If "YES", continue to complete the remainder of this form.  <b>NO</b> If "NO", STOP HERE. A SPECIAL DIET IS NOT WARRANTED.</p>	
<b>17) Disability, Medical Condition, or Severe Food Allergy:</b> Also provide a brief description of the <u>major life activity</u> (i.e. breathing, learning) affected by the disability or <u>severe and/or life-threatening reaction</u> resulting from the food allergy.	
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18) Diet Prescription: (For carbohydrate or protein restrictions, include the level allowed for each meal)

19) Food Allergies: Indicate the level of sensitivity to the food(s) the child is allergic to:

Omit all sources of this food **OR**  Omit major sources of this food (small amounts are tolerated)

20) Food(s) to be Omitted and Suggested Substitutions:

Food(s) to Omit

Suggested Substitution(s)

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21) Texture Modification: If needed, circle one appropriate for the student: **CHOPPED** **GROUND** **PUREED**

22) Physician's Signature

23) Physician's Printed Name

24) Medical License Number

25) Telephone Number & Address

26) Date

27) Name & Phone Number of Registered Dietitian Following Student:

RD/DTR Signature \_\_\_\_\_ Date \_\_\_\_\_

**Send completed form to:**

**First State Montessori Academy**  
**1000 N. French Street**  
**Wilmington, DE 19801**  
**Phone (302) 576-1500**  
**Fax (302) 576-1501, Attention: Nurse Becky & Nurse Laurie**

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