FNS DIET ORDER for Special Nutritional Needs

Annual Medical Statement for Students

Date: _____

Parent/Guardian: Complete Items 1 – 7 (Pader/tutor: Compleata cajitas 1-6)

1) Student's Last Name *(Apellido)*	First Name *(Nombre del estudiante)*	3) Date of Birth *(Fecha de nacimiento)* Age ____	4) Circle Meals Eaten at School *(Circule las comidas que su nino/a come en la escuela)* Breakfast (Desayuno) Lunch (Amuerzo) Snack (Bocadillo)
5) Parent/Guardian Signature *(Firma del Padres/Tutor)*	6) Print Name of Parent/Guardian *(Escriba en letra de molde el nobre del padre/Tutor)*		7) Parent Phone Number(s) *(Numero(s) de telefono del padres* Home *(Casa)*: ( )_____ Cell *(Celular)*: ( )_____ Night Phone #: ( )_____

Mailing Address:

School Attended by Student **Grade:** **School Year: 20 to 20**

Cafeteria Manager: Complete Items 8 - 15

8) School Name (Include EEC name, if applicable)	9) Site Type: Satellite
First State Montessori Academy	

10) School Nurse:	11) School Nurses' Phone #	12) School Fax #
Upper School: Becky Adeleke Lower School: Laurie Murray	(302) 576-1500	(302) 576-1501

13) Cafeteria Manager (C.M.)	14) C.M. Email Address	15) Cafeteria Phone #
Becky Adeleke	rebecca.adeleke@fsma.k12.de.us	(302) 576-1500

Is there an IEP in place at the school that includes dietary restrictions? ___YES ___NO

Physician ONLY: Complete Items 16 - 27

16) Does the student have a disability, medical condition or severe food allergy warranting a special diet?

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.

YES If "YES", continue to complete the remainder of this form.
NO **If "NO", STOP HERE. A SPECIAL DIET IS NOT WARRANTED.**

17) Disability, Medical Condition, or Severe Food Allergy: Also provide a brief description of the **major life activity** (i.e. breathing, learning) affected by the disability or **severe and/or life-threatening reaction** resulting from the food allergy.

_____

_____

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)

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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