



- Initial Diet Order
 Revision to Diet Order

PART A Parent / Guardian: Complete Items 1 - 16 (Padre/madre/tutor: complete la información en los espacios 1 al 16)

1) Student ID# (Numero de estudiante) 2) Student's Last Name (Apellido) 3) Student's First Name (Nombre del estudiante) 4) Date of Birth (Fecha de nacimiento)

--	--	--	--	--	--	--	--

5) School (Escuela) 6) Grade (Grado) 7) Student assigned in:

		<input type="checkbox"/> ECAP <input type="checkbox"/> Pre-K
--	--	--

Parent/Guardian Name & Contact Information (Nombre & Información del contacto)

8) Name (Nombre) 9) Phone Number (Teléfono) 10) Mailing Address, City, State, Zip (Dirección postal, ciudad, estado, código postal)

--	--	--

11) E-mail Address (We will use this to send acknowledgement and details of your child's menu plan. PRINT NEATLY)
Dirección electrónica (será usada para acuso de recibo y detalles sobre el menú de su niño. IMPRIMA)

--

12) Meals Eaten at School (Los alimentos que su niño(a) consumirá en la escuela)

Breakfast (Desayuno) Snack (Merienda) Lunch (Almuerzo) None (Nada)

13) Parent Request: (Solicitud de los padres)

Lactose Intolerance (intolerancia a lactosa) (Lactaid Milk needed) (necesita leche Lactaid)
If lactose intolerant, mark if child CAN eat (marque si puede comer) Cheese (queso) Yogurt (yogurt)

Cultural/Religious Preference (preferencias culturales/religiosas)

No Pork (carne de cerdo) No Beef (carne de res) Other foods to exclude (otro) _____

14) Does the student have an identified disability (IEP or 504 Plan)?
¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)? Yes (Si) No

15) I consent to the exchange of information between the physician and school district, as needed.
(Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)

Parent / Guardian Signature (required for processing) (Firma del padre/madre/tutor - requerido para ser procesado) **X** Date (Fecha) _____

16) Parent/Guardian: It is **REQUIRED** that this completed form is returned to the **School Nurse who will share information with the Nutrition Department**. All further changes to the child's diet **must be made by a physician on a new form** with the exception of lactose intolerance or cultural preference. The cafeteria manager will add the alert to the cashier system & return the form to the District FNS Office for consideration. **By signing above I give Child Nutrition Services permission to speak with the Licensed Medical Doctor (MD) or recognized Medical Authority signing the Diet Order Form to discuss the student's dietary needs described in this form.**
(Padre/madre/tutor: Se REQUIERE que se devuelva la forma debidamente completada al gerente de la cafetería. Cualquier cambio en la dieta del estudiante debe ser hecho por un médico en una nueva forma, a excepción de la intolerancia a lactosa o preferencias culturales. El gerente de la cafetería añadirá un alerta en el sistema de cajeros y devolverá la forma a las oficinas de Alimentos y Nutrición del Distrito)

PART B COMPLETED BY THE PHYSICIAN ONLY: Complete Items 17 - 20 (17 al 20 - Esta sección para ser completada por el médico solamente.)

17) Student Diagnosis or Condition Food Intolerance Food Allergy *Life Threatening Food Allergy *Students with life threatening food allergies must have an emergency action plan in place at school. **Please complete PAGE 2.**

Select One Other (specify) _____

FOOD TEXTURE MODIFICATION If medically needed check ONE: Pureed Ground Chopped

18) Please check all food(s) to **exclude** from child's diet during the school day only (not to be used as a medical history):

<p>DAIRY</p> <p><input type="checkbox"/> Fluid Milk Only</p> <p><input type="checkbox"/> Cheese</p> <p><input type="checkbox"/> Ice Cream</p> <p><input type="checkbox"/> Yogurt</p> <p><input type="checkbox"/> All milk ingredients</p> <p>EGG</p> <p><input type="checkbox"/> Whole eggs only (such as scrambled eggs or hard cooked eggs)</p> <p><input type="checkbox"/> All egg ingredients</p> <p>WHEAT & GLUTEN</p> <p><input type="checkbox"/> Wheat</p> <p><input type="checkbox"/> Gluten</p> <p>FISH</p> <p><input type="checkbox"/> Fish</p> <p><input type="checkbox"/> Shellfish</p>	<p>PEANUTS OR TREE NUTS</p> <p><input type="checkbox"/> Peanuts</p> <p><input type="checkbox"/> Tree Nuts</p> <p>CORN</p> <p><input type="checkbox"/> Whole corn such as corn kernels, tortilla chips, corn muffin</p> <p><input type="checkbox"/> Recipes with corn /corn by-product ingredients</p> <p>SOY</p> <p><input type="checkbox"/> All soy ingredients</p> <p><input type="checkbox"/> Soybean Oil</p> <p><input type="checkbox"/> Soy Lecithin</p> <p>OTHER</p> <p><input type="checkbox"/> Other, specify if it is a cooked ingredient or when consumed fresh</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	--

20) LICENSED PHYSICIAN'S INFORMATION Diet Order Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.

Medical Authority Signature	Date	Please contact the Capital School District Child Nutrition Office if you have any questions about completing this form. Nicola Boyle, Registered Dietitian, Nutrition Specialist nicola.boyle@capital.k12.de.us Office: (302) 857-4251 Fax: (302) 672-1613
X		
Medical Authority Printed Name		

Anaphylaxis Emergency Action Plan

Patient Name: _____ Age: _____

Allergies: _____

Asthma Yes (*high risk for severe reaction*) No

Additional health problems besides anaphylaxis: _____

Concurrent medications: _____

	Symptoms of Anaphylaxis
MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath, cough, wheeze
HEART*	weak pulse, dizziness, passing out

*Only a few symptoms may be present. Severity of symptoms can change quickly.
 Some symptoms can be life-threatening. ACT FAST!

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):
- | | |
|--|---|
| <input type="checkbox"/> Adrenaclick (0.15 mg) | <input type="checkbox"/> Adrenaclick (0.3 mg) |
| <input type="checkbox"/> Auvi-Q (0.15 mg) | <input type="checkbox"/> Auvi-Q (0.3 mg) |
| <input type="checkbox"/> EpiPen Jr (0.15 mg) | <input type="checkbox"/> EpiPen (0.3 mg) |
| Epinephrine Injection, USP Auto-injector- authorized generic | |
| <input type="checkbox"/> (0.15 mg) | <input type="checkbox"/> (0.3 mg) |
| <input type="checkbox"/> Other (0.15 mg) | <input type="checkbox"/> Other (0.3 mg) |

Specify others: _____

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home _____ work _____ cell _____

Emergency contact #2: home _____ work _____ cell _____

Emergency contact #3: home _____ work _____ cell _____

Comments: _____

 Doctor's Signature/Date/Phone Number

 Parent's Signature (for individuals under age 18 yrs)/Date