Capital School District
Child Nutrition Department

Request for Diet Modification
Annual Medical Statement for Students

School Year: _____ *(Año escolar)*

☐ 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: ☐ ECAP ☐ PreK-12

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

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

11) E-mail Address (We will use this to send acknowledgement and details of your child´s menú 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 *(Meriendao)*
☐ Lunch *(Almuerzo)* ☐ None *(Nada)*

13) Allowable 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 *(yogur)*
☐ Cultural/Religious Preference *(preferencias culturales/religiosas)*
☐ Pork *(carne de cerdo)* ☐ Beef *(carne de res)* ☐ Other *(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 *(Sí)* ☐ 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
Select One ☐ Other (specify) _____
** Students with life threatening food allergies must have an emergency action plan in place at school.* ***Please complete PAGE 2.***

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

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

DAIRY
- ☐ Fluid Milk Only Substitute with: ☐ lactose-free milk ☐ soy milk ☐ rice milk
- ☐ Cheese and recipes with cheese listed as an ingredient Ice
- ☐ Cream
- ☐ Yogurt
- ☐ Baked goods with any dairy listed as an ingredient

EGG
- ☐ Whole eggs only (such as scrambled eggs or hard cooked eggs)
- ☐ Baked goods with any egg listed as an ingredient

WHEAT / GLUTEN
- ☐ Recipes with any wheat or gluten-containing ingredient listed

FISH OR SHELLFISH
- ☐ Fish
- ☐ Shellfish

PEANUTS OR TREE NUTS
- ☐ Peanuts
- ☐ Tree Nuts

CORN
- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn / corn bi-products listed as an ingredient

SOY
- ☐ Soy Protein (concentrate, hydrolyzed, isolate, etc.)
- ☐ Soybean Oil
- ☐ Soy Lecithin
- ☐ Recipes with any soy-containing ingredient listed

OTHER
- ☐ Other, specify if it is a cooked ingredient or when consumed fresh

_____
_____
_____
_____

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 **X** _____ Date _____

Medical Authority Printed Name _____

Please contact the Capital School District Child Nutrition Office if you have any questions about completing this form.

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American Academy of Allergy Asthma & Immunology
www.aaaai.org

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):

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **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