

**FOOD SERVICES DEPARTMENT**

2150 East 15th Street • Tucson • Arizona 85719-6316 • (520) 225-4700 FAX (520) 225-4867

# Diet Modification Order Form

**(Submit for student with special needs for school meals.)**

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| Date: |  |
| School: Gale Elementary School | School phone number: 731-4517 |
| School address: 678 S. Gollob Road. Tucson, AZ 85710 | |
| Student's name: Male Female\_\_\_ | |
| Parent/Guardian name: | Phone number: |
| Address: | |

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| **List the disability or medical condition that requires the student to have a special diet or food.**  Include a brief description of the major life activity affected by the student’s disability or reason for the food substitution *(use back of the form if additional space is needed)* |

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| **Diet Prescription**  **List all foods that must be omitted**  *For milk allergies or intolerances to dairy products, please specify which dairy products must be avoided and also specify if milk as an ingredient in foods is okay (crackers, baked goods etc).*  **List what foods can be substituted**  If cow’s milk must be avoided, please check which of the following options can be substituted.  Soy Milk\_\_\_\_\_ Rice Milk\_\_\_\_\_ Juice\_\_\_\_\_  Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Textures allowed**  Regular Chopped Ground Pureed**\***  Tube feeding Liquid by mouth  **\***For Pureed, please specify which stage of baby food is appropriate (I, II or III)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Other information regarding diet or feeding** | | |
| Student's age: | Weight: | Height: |
| Limitations: | | |
| Medications: | | |

**This diet order is**

**\_\_\_permanent** (this diet order will remain in effect during the time the student is enrolled in TUSD. A new diet order will be required to change any aspect of information provided in this diet order.)

**\_\_\_temporary** (this diet order is effective for the current school year. TUSD should confirm annually with the physician if any modifications to the order should be applied.)

I certify that the above named student needs adjustments to the regular school meals as described above because of the student’s disability or medical condition.

Physician signature Office phone Date

Printed name of physician

Address of office

**RETURN TO: TUSD Food Services**

**(Return to the department offices at 2150 E. 15th Street or fax to 520-225-4867)**