PURPOSE: To record the student's condition requiring dietary modifications of school lunch and the changes needed.

PREPARATION: The parent or guardian of the child is responsible for obtaining the form, filling out Part I, requesting completion by a physician and delivering the form to the principal's office at the school attended by the child. A licensed physician is responsible for completing Part II of the document based on the child's medical condition. Consultation by a dietitian for completion of the form if needed should be requested by the parent or physician.

INSTRUCTIONS:

Part I *(to be filled out by the parent or guardian)*:

Name of Student: Enter the student's last name, first name, and middle initial.

Social Security Number: Enter the student's nine-digit social security number, e.g., ### - ## - ####.

Date of Birth: Enter the student's six-digit date of birth, e.g., May 1, 1988 = 05/01/88

Age: Enter the student's one- or two-digit age as of the day the form is completed.

School Attended by Student: Enter the name of the school which the student regularly attends.

Parent/Guardian's Daytime Phone Number(s): If available, enter one or two telephone numbers with the area code where one or two of the guardians can be reached during the daytime.

Name of Parent/Guardian(s): Enter the full name of the student's parent(s) or legal guardian(s).

Signature of Parent/Guardian: Enter the signature of one parent or legal guardian's name. A printed name on the previous line should correspond to the signature.

Part II *(to be filled out by the physician)*:

Patient's Diagnosis: Insert the patient's clincal diagnosis for the condition which requires dietary modification.

Description of the patient's condition and major life activity affected by the condition related to dietary modification: Describe the patient's condition as it affects a major life activity (i.e., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.) Describe how the restrictions of the patient's condition affects his or her diet.

Indicate which dietary modification the patient needs and specify what changes need to be made: Check the type(s) of modication the patient's condition requires and fill in the corresponding specification next to the type of modification. A dietitian can assist in completing this section.

Dietitian's Name (if available): Provide a local dietitian's name and phone number if available.

Physician: PRINT the name, address, and phone number of the physician completing the form.

Physician's Signature: Enter the signature of the physician filling out the form and the date signed.

Additional forms may be ordered from:

Division of School Services
Child Nutrition Services Section
301 North Wilmington Street
Raleigh, NC 27301-2825