



**DIET ORDER for Special Nutritional Needs  
Annual Medical Statement for Students**

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

Name of Student (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Student ID # \_\_\_\_\_

School Attended by Student \_\_\_\_\_ Grade: \_\_\_\_ School Year: 20\_\_ to 20\_\_

Will student eat **Breakfast** at School?  Yes,  No **Lunch** at School?  Yes,  No

After School Snack Program?  Yes,  No

Parent/Guardian \_\_\_\_\_ Email \_\_\_\_\_

Parent/Guardian's daytime phone number ( ) \_\_\_\_\_ - \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Does the child have an identified disability?  Yes  No

If yes, please describe the major life activities affected by the disability: \_\_\_\_\_

I give Child Nutrition Services permission to speak with the below named physician or Authorized Medical Authority to discuss the dietary needs described below. \_\_\_\_\_

Parent/guardian's signature and date

**Part II to be filled out only by a Licensed Medical Doctor (MD) or Recognized Medical Authority treating the student**

Indicate dietary modification the student needs and **specify** what changes need to be made:

**Lactose Intolerance or Dairy Allergy:**  No milk to drink,  Juice in place of milk @ meals  
 Water in place of milk at meals  Avoid all dairy products (including cheese, ice cream, & yogurt)

**Food Allergies:** Check appropriate box(es):  ingestion  contact  inhalation  
 Wheat  Soy  Nuts (Please specify type)  Fish  Eggs (please indicate whole eggs or eggs as an ingredient) **Other** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Texture modification:**  pureed  ground  chopped  thick liquids

**Other** \_\_\_\_\_

\*Information regarding the major allergens (Soy, wheat, Dairy, Eggs, Fish, Tree Nuts and Nuts) and carbohydrate counts will be available on line at [www.rss.k12.nc.us](http://www.rss.k12.nc.us) . Peanuts and shellfish are not served in RSS cafeterias. Diet Order form is not required if this information suffices for parent to manage student's diet.

MD Name \_\_\_\_\_

MD Signature \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

Fax \_\_\_\_\_

Send completed form to your child's school cafeteria or  
Rowan Salisbury Schools Child Nutrition,  
PO Box 2349, Salisbury, NC 28145  
Phone: 704-630-6046 Fax: 704-639-7078

Medical Office Stamp:

RSS Child Nutrition Services Notes:

School Nurse:

Cafeteria Manager:

CN office: