Year: ______________

Wake County Public School System
Child Nutrition Services
Annual Diet Order:

Part I (Must be completed 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____

Parent/Guardian:
Phone Number (s) (   ) _____ - _____ (H), (   ) _____ - _____ (W), (   ) _____ - _____ (Cell)

Name of Parent/Guardian (Print)
______________________________Signature__________________________________

Mailing Address _________________________City _______________ State _____ Zip ________

Will student purchase Breakfast at School? ☐ Yes, ☐ No; Lunch at School? ☐ Yes, ☐ No

Is student in Before School Program? ☐ Yes, ☐ No; After School Program? ☐ Yes, ☐ No

Required

Part II

In order to provide services for your student, Part II must be completed by the Licensed MD providing care related to the diagnosis.

Student's Diagnosis: ____

Dietary Modifications:

Medical Office Stamp:

MD Name (Print) ________________________________

MD Signature___________________________________

Phone ______________________Date________________

CNS USE ONLY:

CNS Dietitian Signature ____**Date**____________

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- **Diet Order forms must be completed by parent/guardian and signed by a physician each year.**
- **Menu adjustments for special diets are provided only to students with diagnosed medical conditions.**

INSTRUCTIONS:

Part I (Must be completed by parent or guardian):

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

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

Age/Student ID #: Enter the student's current age and Student ID #.

School Attended by Student: Enter the name of the school which the student regularly attends, grade, school year

Parent/Guardian Contact Information:

- Current telephone numbers including area codes
- Current mailing address.

Parent/Guardian Name and Signature:

- Print Name
- Provide Signature

Meals Purchased: Indicate if child will purchase, breakfast and/or lunch in school cafeteria.

Before and After School Programs: Indicate if student attends a WCPSS before or after school program.

Part II (Must be completed by Physician (MD) treating the student):

Student's Diagnosis: Clinical diagnosis for the condition, which requires dietary modification.

Indicate dietary modification: Physician (MD) that provides care related to diagnosis must complete this area.

Physician (MD) information:

- Name Printed
- Signature
- Phone Number
- Date signed.
- Medical Office Stamp

For questions please contact: 919-856-2918

Mail completed form to:
Wake County Public School System
Child Nutrition Services
Attention: Registered Dietitian/Diet Orders
1551 Rock Quarry Rd.
Raleigh, NC 27610

June 2009