Year: _____

Wake County Public School System
Annual Dietary Order/Medical Statement for Students
With Special Nutritional Needs

Please return form to
Registered Dietitian
@ Child Nutrition Services
1551 Rock Quarry Rd
Raleigh, NC 27610 or
fax to 919-856-3707

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school. See "Guidance for Completing Medical Statement for Students with Special Nutritional Needs for School Meals" for help in completing this form.

Part 1 (Must be completed by a parent or guardian):

Name of student (Last)_____ (First)_____ (MI) _____

Date of Birth _____/_____/_____ Age _____ Student ID # _____

School Attended by Student _____ Grade _____

Parent or Guardian Name _____ Signature _____

Parent or Guardian Phone Number ( ) _____-_____ (H) ( ) _____- _____ (W) ( ) _____- _____ (C)

Mailing Address _____City _____Zip Code _____

Email Address _____

Will student purchase breakfast at school? ○Yes ○No Will student purchase lunch at school? ○Yes ○ No

Will the student eat an afterschool snack provided by Child Nutrition Services? ○Yes ○ No

What concerns do you have about this student's nutritional needs at school?_____

_____

What concerns do you have about this student's ability to safely participate in mealtime at school?

_____

_____

Does the student have an identified disability and an Individualized Education Program (IEP) or 504 Plan?

○Yes ○No

Parental/ Guardian Consent: I agree to allow my child's health care provider and school personnel to discuss the information on this form:

Signature _____ ***Date*** _____

**Please note that special dietary needs for students without an IEP or 504 Plan are accommodated at the discretion of the Child Nutrition Registered Dietitian and the policies of the School District.*

Part 2 In order to provide services for your student, Part 2 must be completed:

(Note: A licensed physician's s signature is required for students with a disability. For students without a disability, a licensed physician or recognized medical authority must sign the form. Recognized medical authorities include physicians, physician assistants, and nurse practitioners.)

Student diagnosis: _____

Dietary Modifications: *please include texture modifications, liquid modifications, foods to be omitted, and other as needed*.

MD Name (Print) _____

MD Signature_____

Phone ( ) _____-_____ Date: _____

Medical office stamp

Child Nutrition Use Only:
Dietitian Notes

_____

_____

_____

_____

_____

_____

_____

_____
Dietitian Signature