Brunswick County Schools

DIET ORDER/ MEDICAL STATEMENT

SEND COMPLETED FORM TO:
SCHOOL NURSE
Brunswick County Schools
35 Referendum Drive
Bolivia, NC 28422

Part I (to be filled out completely by parent or guardian) ***New forms must be completed annually.***

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

Date of Birth_____/_____/_____ Age _____ Student ID #(NCWise#)_____

School Attended by Student _____Grade:_____ School Year: 20__

Which school meals will the student be eating: ☐**BREAKFAST** ☐**LUNCH**

Parent/Guardian(**print**)_____Email _____

Parent/Guardian Phone Number(s)_____(H)_____(W)_____(C)
Mailing Address: _____City:_____ State _____ Zip _____

• PARENTAL RELEASE OF INFORMATION: I give Brunswick County Schools Special Needs/Nurse/Child Nutrition permission to speak to the below-named licensed physician to discuss the dietary needs described below.

Parent/Guardian signature:_____ Date:_____

Part II (to be completed only by a licensed physician (MD)

DIAGNOSIS:_____

Does the child have an identified disability? Yes _____No_____ **(**If yes, Part II must be completed and signed by a **LICENSED PHYSICIAN ONLY)**

Describe the major life activities affected by the disability:_____

Specify any dietary restrictions or special diet instructions for school meals:_____

MODIFICATIONS:

DESIGNATE CONSISTENCEY REQUIREMENTS FOR FOODS:

□ Clear liquid	□Pureed	□Blenderized Liquid
□Full Liquid	□Mechanical Soft	□Chopped

DESIGNATE CONSISTENCEY REQUIREMENTS FOR LIQUIDS:

□Thin	□Honey-like
□Nectar-like	□Spoon-Thick

*For any special diet, list specific foods to be omitted and suggested substitutions; You may attach a separate page with additional information.

FOODS TO BE OMITTED:	**SUGGESTED SUBSTITUTIONS:**

DIABETES: Please indicate the grams of carbohydrates for: Breakfast _____ Lunch:_____

FOOD ALLERGIES: If student has **LIFE THREATENING/ANAPHYLACTIC** allergic reactions, check appropriate box: □Ingestion □Contact □Inhalation □All

List foods to avoid:_____

List foods to be substituted:_____

Other(be specific)_____

Physicians (MD) Name:_____
Physicians Signature:_____
Phone#:_____**FAX**_____
Date:_____

Medical Office Stamp(Required)

PART III (Child Nutrition Department to complete)

BCS Child Nutrition Department Notes:

Child Nutrition Administrator Signature:_____Date:_____

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(Revised 10/5/2010)