School District of Altoona
Food and Nutrition Department

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http://www.altoona.k12.wi.us/foodservice

"On Track with Altoona Food Service"

PHYSICIAN ORDER FOR DIET MODIFICATION

SCHOOL YEAR______________________________

PART I (TO BE COMPLETED BY PARENT/GUARDIAN)

Name of student____
Birth date___________________________Age_______Grade______Sex_____
Name of Parent/Guardian____
Address____
Phone (H)______________(W)____________________(Cell)______________
Teacher's name____
I hereby request my child,________________________, receive a modified diet as prescribed by my child's physician.

DATE: ________PARENT/GUARDIAN SIGNATURE: _____________________

PART II (TO BE COMPLETED BY PHYSICIAN)

Diagnosis or statement of medical need _______________________________________
____
Diet order (including food modification) ____
____
Food(s) to be omitted from or substituted in the diet (attach food plan if available) ________
____
Adaptive equipment required____
Precaution (i.e. choking, anaphylactic shock, etc.)___________________________________
____

This diet modification is to be followed through current school year __________________
This diet order will be automatically discontinued at the end of the current school year

DATE_____________
NAME OF PHYSICIAN (TYPE OR PRINT) ___________________________________
CLINIC /HOSPITAL/OFFICE____
TELEPHONE NUMBER____
SIGNATURE OF PHYSICIAN____