Diet Order

Annual Medical Statement for Students with Special Nutritional Needs

Send completed form to:
Rock-Hill School District Three
Office of School Food Services
660 N. Anderson Road
Rock Hill, SC 29731
Phone: (803) 981-1016 Fax: (803) 981-1097

This form must be filled out at the start of each school year, and whenever diagnosis or change is indicated. The parent or guardian is responsible for obtaining the form, filling out Part I, requesting completion by the student's physician or dietitian, and delivering the form to the school nurse or the Office of School Food Services.

Part I (To be completed by parent or guardian) **School Year _____**

Name of Student (Last) _____ (First) _____ (MI) ____
Date of Birth ___/ ___ /___ Age _____ Student ID# _____

School Attended By Student _____ Grade _____
Will student eat breakfast at school? □Yes □No; Lunch at School? □Yes □No
Is student in an after school program? □Yes □ No

Parent/Guardian ( ) _____-_____ (h), ( ) _____-_____(w), ( ) _____- _____(cell)

Part II (To be filled out by a Licensed Medical Doctor (MD) or Registered Dietitian (RD) treating the student).

Student's Diagnosis _____

Indicate which dietary modification the patient needs and specify what changes need to be made.

□ Texture Modification: □Pureed □Ground □Chopped □Other _____

□Nutrient Modification: (Cholesterol, Sodium, Gluten, etc.) _____

□Lactose Intolerance:
□No milk to drink. □Avoid ALL dairy products.

□Diabetic □Diet Controlled □Insulin Dependent

□**Food Allergies: Please check appropriate box(es):**
□**Ingestion** □**Contact** □**Inhalation**
Please list allergen, foods to be avoided, and acceptable substitutes.

Allergen	Foods To Be Avoided	Acceptable Substitutes
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list type of reaction (hives, wheezing, etc), and intervention (Epi Pen, etc.) to be provided upon exposure to allergen(s) listed.

_____
_____
_____

(Over)

Please list any special equipment or utensils that are needed.
_____
_____

Parent's Signature: _____ Date: _____

MD Name: _____

MD Signature: _____

Phone: _____

Medical Office Stamp:

OR

RD Name:_____

RD Signature: _____

Phone: _____

Part III (To Be Completed By Office of School Food Services)
RHSD Nutrition Services Notes:

RHSD RD Signature: _____ Date: _____