Coolidge Unified School District
Food & Nutrition Department

SPECIAL DIETARY NEEDS FORM

The attached form is required for any menu substitutions or accommodations due to special dietary needs and must be signed by a recognized medical authority (Physician, Physician's Assistant, or Nurse Practitioner).

Instructions for Completing the Special Dietary Needs Form

Part I (to be filled out by parent or guardian):

- Name of Student: Enter the student's first and last name.
- Date of birth: Enter the student's date of birth.
- School: Enter the name of the school that the student regularly attends.
- Name of Parent/Guardian(s): Enter the full name of the student's parent(s) or legal guardian(s).
- Phone: Enter the parent/guardian's daytime phone number with area code.

Part II (to be filled out by the Physician, Physician's Assistant, or Nurse Practitioner):

- Diagnosis: Indicate the patient's clinical diagnosis for the condition that requires dietary modifications.
- Foods to be omitted from the child's diet: Indicate which foods must be omitted from the child's diet for medical reasons.
- Foods to be substituted: Indicate appropriate substitutions for the foods which are to be omitted. (A Registered Dietitian Nutritionist can assist in completing this section)
- Special Considerations: List any special considerations that affect the child's diet.
- Please check: Place a check mark next to the corresponding line for the child's condition--(life-threatening, managed by child with moderate supervision, or self-controlled by the child).
- Contact Information: Print the name, address and phone number of the medical authority completing the form.
- Physician/PA/NP Signature: Enter the signature of the physician, physician's assistant, or nurse practitioner filling out the form and the date signed.

PARENT/GUARDIANS PLEASE NOTE:

Special diet requests can take 3-4 weeks to process. Please plan to send a lunch with your child until you receive verification that your child's special diet request has been reviewed and accommodations can be made. Coolidge Unified School District reserves the right to request this form be completed on an annual or as needed basis.

Please return to: Wesley Delbridge, RDN, SNS
wesley.delbridge@coolidgeschools.org
450 North AZ Boulevard, Coolidge, AZ 85128

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Part I (to be filled out by Parent or Guardian):

Child's name: _____School: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone: ( ) _____

Address: _____

City: _____State: _____ Zip code: _____

E-mail Address: _____

Have you completed a CUSD Special Dietary Needs Form for your child in previous years? YES NO

Part II (to be filled out by the Physician/PA/NP):

Please complete the following for the above child. List all foods that should be omitted from the diet and any foods or types of foods that may be substituted. If there are any special considerations needed for meal service, please list them in the space provided below.

Diagnosis requiring diet modifications:

_____

Foods to be omitted from child's diet:

_____

Foods to be substituted:

_____

Special considerations:

Please check one of the following:

- ☐ **Life threatening**
- ☐ **Managed by child with moderate supervision**
- ☐ **Self-controlled by child**

Physician/PA/NP Contact Information:

Name: _____ **Phone:** _____

Address: _____

Physician/PA/NP Signature: _____ **Date:** _____

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