Nassau County Food & Nutrition Services
Special Diet Request Form School Year 2020-21

This form must be completed and returned to Food & Nutrition Services. All changes must be made by a physician with the exception of lactose intolerance. By signing this form, you give Food & Nutrition Services the right to contact your child's physician for clarification regarding dietary restrictions. The school cafeteria manager, Food & Nutrition Services office, and school nurse will receive a copy. If a doctor's note is not provided with this from please have the physician fill out Section B.

Section A: Must be completed by the Parent/Guardian

Name of Student: ______________________________________ Student ID:________________________ Grade:_____

School Name: ____ Teacher's Name: _____________________________

Does the student typically receive a meal from Nassau County Food & Nutrition Services (NCFNS) ____Yes ____No

If yes, which meals provided by NCFNS will your child be eating? ______ Breakfast ____ Lunch ____ Snack

Parent/Guardian Printed Name _________________________________ Signature _______________________________

Day Time Phone Number _________________________ Email __________________________ Date ______________

Lactose Intolerance: Completed by Parent/Guardian

Is student Lactose Intolerant ____ Yes ___ No. If yes, can the student have ____Cheese ____Yogurt ____Ice Cream

Section B: Must be completed by the physician if a doctor's not is not provided.

Does the student have a disability, medical condition, or severe food allergy/intolerance warranting a special diet?

____ Yes (Please continue to fill out the remainder of the form) ____ No (A special diet is not warranted)

Disability/Medical Condition: State the disability and a brief description of the major life activity affected by the food related disability.

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Check all food(s) to omit from the child's diet at school only (not to be used as medical history):

____ Milk ____ Egg ____ Soy ____ Peanut ____ Tree Nut ____ Fish ____ Shellfish ____ Wheat/Gluten

____ Other ____

Suggested Substitutions: ____

Indicate the severity to the food(s) the child is allergic to by checking below:

___ Omit all sources of this food OR ___ Omit major sources of this food (i.e. egg/milk in baked goods is ok)

Texture Modification: ___ Chopped ___Ground ___ Pureed ___ Mechanical Soft

Comments: ____

Physicians Signature:__________________________ Phone:______________________________ Date: ___________