DALLAS TORAH CENTER
Preschool

DTC PRESCHOOL DIETARY ORDER FORM

Name: _____ DOB:_____

Physician Name: _____

Physician Phone: _____ Physician Fax: _____

Diagnosis/ Disability: _____

How does this handicap/disability restrict the child's diet? _____

_____

Major life activity affected by disability (circle all that apply): Eating Walking Seeing Hearing Speaking Hearing Speaking Learning Performing Manual Tasks Breathing

Dietary Prescription

Diet Order (specify calories, carbohydrates, sodium, etc): _____

Foods to omit due to allergies: Dairy Peanut Butter Wheat Eggs Citric Acid Other: _____

Food to be substituted: _____

Duration of time for special diet/restriction: _____Weeks _____Months _____Until end of school year

Textures allowed (circle all that apply): Ground Pureed Chopped Other Regular

---

Below for physician office use only

I _____, (physician's name) declare the child listed above to possess the following life threatening food allergy.

1. *Life threatening food allergy- omit these foods (circle all that apply)*

   Milk Peanuts Tree Nuts Eggs Fish Shellfish Wheat Soy

2. *Can the student consume foods where the allergen is an ingredient in the food product? (Example: scrambled eggs are omitted but egg as an ingredient in pancakes is allowed).*

   Yes No *Explain* _____

3. *Other life threatening food allergies- omit these foods (list all):* _____

_____

I certify that the above named child required nutritionally modified meals as described above due to the child's disability.

Signature of Physician: _____ Date: _____

Below for parent/guardian use only

I give permission for the school staff to follow the above nutrition plan.

Parent/Guardian Signature: _____ Date: _____