Albuquerque Public Schools
Food & Nutrition Services/Nursing Services

Albuquerque Public Schools
Special Diet Authorization Form

This form MUST be completed and signed by a licensed healthcare provider in order for a student with a disability or medical/dietary need to receive modifications or substitutions to the regular school meals. A new form must be completed EVERY school year.

Date: ___________

Student Name: ______________________________ Student Number: ____________________

Date of Birth: ____________________ School: ____

Parent/guardian: ______________________________ Phone number: ____________________

HEALTHCARE PROVIDER PLEASE COMPLETE AND SIGN:

Diagnosis(es): ____ ICD-10 code(s): ______________

Describe the Student's ☐ **Disability** or ☐ **Medical Condition** that requires the student to have a special diet and the major life activity affected by the student's disability or condition:

____

____

History of anaphylactic reaction due to severe food allergy: ☐ Yes* ☐ No

*If yes, please also complete an *Allergy Action Plan* for epinephrine at school and return to the School Nurse.

History of allergy testing to indicate food allergy: ☐ Yes ☐ No

Intolerance to foods? If yes, which foods? ____

List food(s) to be omitted from the diet and food(s) that may be substituted:

Omit: ____

Alternatives: ____

Healthcare Provider's Signature: ____________________ Printed Name: ____________________

Phone Number: ____________________ Fax Number: ____________________

Address: ____

Registered Dietitian consulting with the patient:

Name: ______________________________ Phone Number: ____________________

Please return this completed and signed authorization form to the School Nurse

Copies to: APS School Nurse, School Cafeteria Manager, APS Special Needs Dietitian
Revised: 4/2010, 9/2015, 7/2016