MD Dietary Orders

Fax: 770.535.0252 (Attn: Nursing)

Child's Name:_____***Dx:***_____***DOB:***_____

___ Egg Allergy

___ Gluten-Free Diet

___ Lactose / Casein (circle) free diet.

___ Peanut / Tree nut allergy (circle).

___ Soy Allergy

___ Other Food Allergy/Sensitivity:_____

___ Please allow child to have foods/drinks provided from home. (circle all that apply)

- soft foods / pureed food / baby food / other: _____
- Pediasure / Almond milk / Soy milk / 100% Juice (circle)

___ Due to an aversion to certain foods/textures, please allow child to have food choices that may not comply with Federal Guidelines regarding nutrition.

___ Child may use: Adaptive cup / Sippy cup (circle) from home.

Other adaptive eating utensils:_____

M.D. Note:_____

_____

Physician Name: _____**Signature:**_____**Date:** _____

****Any child with a dietary note may have to provide all food (lunch/snacks) from home depending on the severity of restrictions.***