

**VISITATION CATHOLIC STEM ACADEMY
SPECIAL DIET ORDER**

Please provide the following diet instructions for students with allergies who will be using the Visitation Catholic STEM Academy Lunch Program.

Student Name _____ D.O.B. _____

Parent Signature _____ Date _____

HEALTH CARE PROVIDER: Please complete and sign medical orders below

Diagnosis/Allergen:

Diet Order: Please specify restricted foods if indicated.

How does the ingestion of the food/beverage affect the child:

List all foods/beverages to be substituted:

Please Note: For students with **severe food allergies**, Visitation Catholic STEM Academy purchases foods from manufacturers that use shared equipment that also processes nuts and milk, or use a facility that also processes nuts and milk. Advise school and parents accordingly if the above student with severe nut allergies will need to pack their lunch.

Healthcare Provider's Signature

Date

Provider's Name _____

Provider's Address _____

Phone _____

Fax _____

Please fill out contact information
or stamp here.

Please return this form to the Visitation Catholic STEM Academy Office.

Phone: 253-474-6424

Fax: 253-474-6718

Administrative Assistant: Please give a copy to the Kitchen Manager.