ALBUQUERQUE PUBLIC SCHOOLS

APS Special Diet Authorization Form

Below is a special diet authorization form for Albuquerque Public Schools (APS) that must be filled out and signed by a licensed healthcare provider. This form is used for a student with a disability or medical need to receive meal modifications or substitutions at school.

A new form is required for each student at the start of each educational stage (K-5, 6-8, K-8, and 9-12), or if there are changes to the student's special medical needs or allergens.

Student Information:

Student Name: _____ DOB: _____ Student ID: _____School: _____
Parent/Guardian Name: _____ Phone Number: _____
Meals student will eat at school (check all that apply):
☐ Breakfast ☐ Lunch ☐ Snack (If available) ☐ Energy Booster-Dinner Program (If available)

HEALTHCARE PROVIDER: Please Complete, Sign, and Date

Diagnosis (es): _____ICD-10 code(s): _____
Describe the student's disability/health condition that requires the student have a special diet: _____
_____

Is this need a: ☐ food allergy? ☐ food intolerance? ☐ health condition requiring modified diet?

Food Omission due to:

Food Allergy***:***

- History of anaphylactic reaction due to severe food allergy: _____Yes _____No If yes, you must also complete an Allergy Action Plan for care (including an order for epinephrine) at school and return the form to the School Nurse.
- History of allergy testing to indicate a food allergy: _____Yes _____No Date of testing:_____
- Please list the food(s) to be omitted from the diet below. (Please be specific when describing a student's allergen, for example: "can have eggs or milk baked into recipes, but no scrambled eggs or fluid milk." _____
  _____

Food Intolerance:

- Please list the food(s) to be omitted from the diet here:_____

Dietary Modification Needed *(due to health condition noted above ie. Type 2 Diabetes, Celiac, Other)**:***

Modifications needed: _____
_____
_____

Mechanical Modification *(complete the Medical Permission To Administer Oral Feeding provider order form and return to the school nurse)*
☐ Diet format/texture: __chopped___diced ___pureed ___ground ___other:
_____

****

Healthcare Provider Name:_____Signature:_____
Phone: _____ Fax:_____Email: _____

Date student seen and plan created: _____

Please return this completed and signed authorization form to the school nurse.
A copy to be kept on file with: APS School Nursing, School Cafeteria Manager, and APS Food and Nutrition Services (FANS).

APS Food and Nutrition Services
Revised: 4/2010, 9/2015, 7/2016, 3/14/2022, 9/22/2025, 6/2026