Physician's Request for Special Dietary Accommodations

All sections must be completely filled out before form will be accepted.

Date: _____

School Year: _____

Part I (To be completed by Parent/Guardian)

Name of Student (Last):_____ **(First):**_____ **Date of Birth:**____/____/_____

School Attended:_____ **Grade:**_____ **Student ID#:**_____

Which meals will the child eat at school (please circle)? Breakfast Lunch After School Snack Supper

School Nurse/Nurse Consultant:_____ **Contact Information:**_____

Parent/Guardian:_____ **Phone #:**_____ **E-mail:**_____

I give Heath Services/Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

_____

Parent/Guardian Signature Date

Part II (To be completed by School Nurse or Physician)

Does the child have a disability (please circle)? Yes No

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such an impairment or is regarded as having such an impairment.

If yes, please describe the major life activities affected by the disability:_____

Does the child have a life-threatening food allergy? Yes No

If yes to any of the above questions, Part III must be completed and signed by a Licensed Physician.

If no to both questions, Part III may be completed and signed by a Licensed Physician or Recognized Medical Authority.

Part III (To be completed by Licensed Physician or Recognized Medical Authority [i.e. Physician Assistant or Advanced Practice Nurse)

Medical Diagnosis:_____

Foods to be avoided:

_____Fluid milk _____All dairy products _____All milk protein (casein, whey, etc.) _____Soy protein

_____Wheat _____Gluten _____Eggs _____All egg protein (albumin, etc.)

_____Seafood _____Corn (as major ingredient) _____All corn additives (dextrin, caramel color, etc.)

_____Peanuts _____All nuts _____All foods produced in a facility with nut containing products

_____Other (Please be specific):_____

Foods to be substituted:_____

(For non-disabled students who cannot have fluid milk, nutrition services will choose the most appropriate milk substitute.)

Texture Modification:_____Soft _____Minced _____Pureed Other (specify)_____

Name of Medical Authority (please print):_____

Signature:_____ **Date:**_____

Phone:_____ **Fax:**_____

Mailing Address:_____

Send completed forms to school nurse/nurse consultant. **Physician requests must be renewed each school year.**

Any change of treatment must be requested in writing by the physician. To ensure that the request is processed prior to the first day of school, submit the request no later than one month prior to the first day of school