Notificación del Médico para Regímenes Alimenticios Especiales

Todas las secciones deben estar <u>completamente</u> llenas antes de que se acepte el formulario.

Fecha: ______________

Año Escolar: ____________

Parte I (Para ser completado por el padre/tutor)

Nombre del Estudiante ______________________________ **Fecha de Nacimiento:**____/____/_____

Escuela:________________________ **Grado:**__________ **#de ID:**______________

¿Qué comidas comerá el niño en la escuela (por favor circule)? Desayuno Almuerzo Bocadillo Cena

Enfermera de Consulta:______________________ **Información del Contacto:**______________

Padre/Tutor:____________________ **# de Tel:**_____________ **E-mail:**__________________

Yo doy permiso al los Servicios de Salud/ Servicios de Nutrición para hablar con el médico nombrado abajo o autoridad médica competente para discutir las necesidades dietéticas que se describen a continuación

____

Firma del Padre/Tutor Fecha

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, <u>Part III must be completed and signed by a Licensed Physician.</u>

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:____

Envie el formulario cumpleto a la enfermera de la escuela/enfermera de consulta. **Las peticiones médicas deben ser renovadas cada año escolar. Cualquier cambio de tratamiento debe ser solicitado por escrito por el médico.** Para asegurarse de que el formulario sea procesado antes del primer día de clases, presente el formulario a más tardar un mes antes del primer día de clases

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