

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

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