MEDICAL STATEMENT FOR STUDENTS REQUIRING SPECIAL MEALS AND/OR ACCOMMODATIONS

Please note: This statement must be updated annually **and** when there is a change or discontinuance of a diet order.

Student's name_________________________________ **Birth date**______________________________ **Gender** ☐M ☐F
School attended_________________________________ **Grade**____
Parent/guardian name___________________________ **Primary phone**______________ **Alternate Phone**___________
Physician/Medical Provider's Name____________________________________ **Phone**____________________________

****FOR PHYSICIAN'S USE ONLY**** (TO BE COMPLETED BY A LICENSED PHYSICIAN)

Indicate medical diagnosis necessitating food restriction, substitution, or special diet. ___________________________

Check major life activities affected by the student's disability or medical condition.

☐Caring for self ☐Eating ☐Performing manual tasks ☐Walking ☐Seeing ☐Hearing

☐Speaking ☐Breathing ☐Learning ☐Working ☐Other_________________________

☐Major bodily function (i.e. immune system, neurological, respiratory, circulatory, endocrine, &reproductive functions)

☐Life-threatening (Epinephrine required)

Diet prescription (check all that apply)

☐Food allergy (please specify all)____

☐Diabetic (attach meal plan) ☐Calorie level (attach meal plan ☐Modified Texture (describe)________________

☐Other (describe)____

OMITTED FOODS/BEVERAGES	ALLOWED SUBSTITUTIONS

☐ Please check here if additional food lists are included in the order.

****If milk allergy listed above in the omitted box, please specify fluid milk substitution:**___________________________
*****If lactose intolerance, please specify one of the following:**

☐ No fluid milk only (may have cheese, yogurt, pudding, ice cream, ect.)

☐ No milk products (no fluid milk, yogurt, cheese, pudding, ice cream, ect.)

☐ No milk products and no products prepared with milk (ie. no breads, desserts, or other products prepared with milk)

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PHYSICIAN/MEDICAL PROVIDER'S SIGNATURE DATE

PARENT/GUARDIAN: I understand it is my responsibility to instruct my child not to share food items or eat any food item except those prepared for him/her in our home or by the school according to these prescribed orders. I further authorize the above diet orders as prescribed. (Both provider and parent/guardian signatures are required to authorize these diet orders.)

Parent/Guardian Signature: __________________________ Date: ________________

School Nurse: __________________________ Signature: __________________________ Date: ________________

Nutrition Manager: __________________________ Signature: __________________________ Date: ________________

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