Updated 12/18/2017

Medical Statement for Special Dietary Accommodations

In order for your child to have their school meal modified or substituted, please have a State Recognized Medical Authority fill out this form in full.

OFFICE STAFF ONLY

Send to Nutritionist as soon as form is received.

Date Received: _____ Initials: _____

Complete: ☐ Incomplete: ☐

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

Parent/Guardian: _____ Phone Number: _____ Email: _____

I give Student Services/Child Nutrition Services permission to speak with the below named medical authority to discuss the dietary needs described below.

Parent/Guardian Signature _____ Date: _____

Part II (To be completed by a State Recognized Medical Authority only)

Medical Condition: _____

Does this medical condition restrict the student's diet? Yes No

If yes, please explain how the medical condition or disability restricts their diet:

_____

_____

Does the child have a food allergy? Yes No

If yes to any of the above questions, Part III must be completed and signed by a State Recognized Medical Authority. If no to both questions, accommodations are not required to be made through Child Nutrition Services.

Foods to be omitted due to food allergy or disability:

____ Wheat	____Gluten	____Eggs	____All egg protein (albumin, etc.)
____ Soy protein	____Cow's Milk	____All dairy products	____All milk protein (casein, whey, etc.)
____ Seafood	____ Peanuts	____ All Nuts	____Tree Nuts

Other (please be specific): _____

Foods to be substituted: _____

Texture Modification: _____ soft _____ minced _____ pureed ____ other (specify) _____

Other dietary modifications required:

_____

This diet order is: _____ Permanent (this diet order will remain in effect during the time the student is enrolled in LESD. A new diet order will be required to change any aspect of information provided in this diet order.)

This diet order is: _____ Temporary (this diet order is effective for the current school year. A new form will be required annually.)

Name of Medical Authority (please print): _____

Signature:_____ Date: _____

Phone: _____ Fax: _____

Mailing Address: _____

Send completed forms to the Child Nutrition Department. Fax: 602-237-7408, Email: jswier@laveeneld.org. For questions call 602-237-9100. Accommodations may take up to 10 business days to begin.

INSTRUCTIONS

Part I (to be filled out by parent or guardian):

Name of Student: Enter the student's last name then first name in the appropriate fields
Date of Birth: Enter the student's six-digit date of birth, e.g., May 21, 1988 = 05/21/88.
School Attended: Enter the name of the school that the student regularly attends.
Circle which meals the child eats at school: You may circle multiple options. Please circle even if the child only eats the meals occasionally.
Parent/Guardian: Enter the full name of the student's parent(s) or legal guardian(s).
Phone number: Complete with the area code(s) and phone number for a parent(s)/guardian(s)
Email: Complete email address for the parent(s)/guardian(s)
Signature of Parent/Guardian: Enter the signature of one parent or legal guardian's name. Enter the date when the form was signed.

Part II (to be filled out by medical authority):

Medical Condition: Enter the patient's clinical diagnosis for the condition which requires dietary modification.
Circle Yes or No if the medical condition restricts the patient's diet.
Explain how the medical condition restricts their diet: This is a description of the patient's condition related to dietary modification. Indicate the necessary dietary modification and specify the changes to be made.

Check Yes or No if the child has a food allergy.

Check all of the foods that need to be omitted due to a food allergy, medical condition, or disability. If the item is not listed, please fill in additional foods items under "Other".

Foods to be substituted: State which food substitutions, *if any*, must be made related to the medical condition or food allergy.

Texture Modification: Check the appropriate texture if meals need to have a specific texture modification. Skip over this part if it is not necessary to the medical condition or food allergy.

Other dietary modifications required: Provide an explanation of what must be done to accommodate the child if it is not listed above. For example, this could include caloric modifications related to a medical condition.

Check if the diet is order is permanent or temporary. The diet order is permanent if the child will need to have dietary modifications for the rest of their life. The diet order is temporary if the diet modification is necessary for one year or less.

Name of Medical Authority: Print the name of the medical authority completing the form.
Medical Authority Signature: Enter the signature of the medical authority filling out the form and the date signed.
Enter the phone, fax, and mailing address of the medical authority.

Recognized Medical Authority: The seven medical professionals listed below are permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs administered in Arizona.

- Physicians (A.R.S. §§ 32-1451(N), 32-1491)
- Physician Assistants (A.R.S. § 32-2532)
- Dentists (see A.R.S. §§ 32-1263.01(E), 32-1298)
- Nurse Practitioners (A.R.S. § 32-1663(G))
- Homeopathic Physicians (A.R.S. §§ 32-2934(O), 32-2951)
- Naturopathic Physicians (A.R.S. §§ 32-1501, 32-1551(I), 32-1581)
- Osteopathic Physicians (A.R.S. §§ 32-1855(J), 32-1871)