Updated 8/1/2023

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)

Student ID#:_____

Name of Student *(Last)*: _____ *(First)*: _____

Date of Birth: ___/___/____ **School Attending:** _____ **Grade:**_____

Which meals will the child eat at school? *(please circle all that apply)*: **Breakfast** **Lunch** **After School Snack**

Parent/Guardian: *(First and Last)* _____ **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)

Please provide a brief description of how ingestion, contact, inhalation and/or exposure to the food affects the child:

_____

Does the child have a life-threatening food allergy? Yes No **If yes, has an Epi-Pen been prescribed?** Yes No

If yes to any of the above questions, Part II 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 from this student's diet:

☐ Fluid Milk*	☐ Milk in baked goods	☐ All dairy products (cheese, yogurt)	☐ All milk protein (whey, casein, etc.)
☐ Wheat	☐ Gluten	☐ Corn (as major ingredient)	☐ All corn additives (dextrose, dextrin, caramel color, etc.)
☐ Peanuts	☐ Fish	☐ Soy Protein	☐ Soy derivatives (soybean oil, soy lecithin, soy albumin, etc.)
☐ All nuts	☐ Shellfish	☐ Fruit: _____	☐ Vegetable: _____
☐ Coconut	☐ Whole Egg	☐ Egg in baked goods	☐ All egg protein (albumin, globulin, lysozyme, etc.)

☐ Other (please be specific): _____

Does this student need to sit at a peanut-free or allergy-free table in the cafeteria? Yes No

Foods/beverages that can be used as a substitute: _____

Texture Modification: ☐ **Soft** ☐ **Minced/ground** ☐ **Pureed** ☐ **Other** (specify) _____

This diet request 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 request 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)*: _____

Medical Authority's Signature: _____ **Date:** _____

Phone: _____ **Fax:** _____

Mailing Address: _____

Send completed forms to the Child Nutrition Services. If any changes occur to the child's diet, please update the Child Nutrition Department immediately. A new form may be required. For questions, please contact Child Nutrition Services.

Send completed form to the Laveen Elementary School District Child Nutrition Services via fax or scan/email.

Phone: 602-237-9100 Fax: 602-237-7408 Email: specialdiets@laveeneld.org.

Accommodations may take up to 10 business days to begin.

**If your child is lactose-intolerant and is able to drink Lactose-Free or Soy Milk, no medical authority signature is required. Any other accommodations require a state recognized medical authority's signature.*

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)