MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY ACCOMMODATIONS

Requiring Dietary Accommodations in the U.S. Department of Agriculture (USDA) Child Nutrition Programs (National School Lunch Program, School Breakfast Program, Afterschool Snack Program, Summer Food Service Program)

PART 1 – TO BE COMPLETED BY PARENT/GUARDIAN. *PLEASE PRINT.*

Child's Name: _____ Birth Date: _____

School Attended by Student: _____ Grade: _____ Student ID#: _____

Parent/Guardian Name: _____

Work Phone: _____ Home Phone: _____ Email: _____

Parent/Guardian Signature: _____

PART 2 – TO BE COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL*

For purposes of Child Nutrition Programs, only a "Licensed Healthcare Professional" is permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs. The seven medical professionals listed are permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs administered in Arizona. (HNS# 11-2015).* ***Dentists*, ***Homeopathic Physicians***, ***Naturopathic Physicians***, ***Nurse Practitioners***, ***Osteopathic Physicians***, ***Physician Assistants***, *and* ***Physicians***.

A. Describe the patient's physical or mental impairment that substantially limits one or more life activities (i.e. seeing, walking, speaking, learning, eating, breathing, etc.) and/or major bodily functions (immune system, digestive, bowel, bladder, etc.) and how it restricts the child's diet.

B. List foods/ingredients to be omitted from the diet.

C. List foods/ingredients that can be substituted into the diet to accommodate the dietary restriction.

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

This diet order is: ___ Temporary *(This diet order will remain in effect for the current school year. A new diet order will be required annually.)*

Licensed Healthcare Professional Name: _____ Office Phone Number: _____

Licensed Healthcare Professional Signature: _____ Date:_____

Return the completed form to Child Nutrition Department by Fax: 602-707-2040, Email: calexander@osbornsd.org . For questions, call 602-707-2021. Accommodations may take up to 10 business days to begin.