Director of Nutrition Services

District Nurse for Health Services

Date: August 2020

Dear Parent/Guardian:

As of the 2020-2021 School Year we are asking all parents of children with food allergies to update their information. If your child has a food allergy, you and your physician/nurse practitioner must complete and sign the Dietary Prescription form attached to this letter. The Office of Nutrition Services will work to provide meal substitutions where possible based on the dietary order your physician prescribes and the USDA requirements. Substitutions cannot be made without this form signed by the student's physician or nurse practitioner.

Completed forms must be returned to the District Nurse, Director Nutrition Services, or School Nurse. These forms will be shared with both Health Services and Nutrition Services
Diet Prescriptions are taken very seriously for the well-being of your child. Changes to this Dietary Prescription once on file cannot be changed unless the student's physician/nurse practitioner has indicated this on a new Diet Prescription form.

We care about your child's health and your help is vital in keeping children safe with food allergies.

Sincerely,

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Samantha Sons
District Nurse for Health Services
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For Special Nutritional Needs:
Annual Medical Statement for Students

Part 1. To be filled out completely by parent or guardian ⇨

Student's Full Name, please print

Last_____ First_____ Middle _____

Date of Birth _____Age_____ Student ID# _____

School _____ Grade_____ School Year_____ to_____

Will your student eat breakfast at school? ☐ Yes ☐ No Lunch at School? Yes ☐ No ☐

Parent/Guardian Name, please print _____

Daytime telephone number/cell _____ E-mail

_____

Mailing Address_____City_____ __State_____ Zip_____

I give Nutrition Services permission to speak with the below-named physician or authorized medical authority to discuss the dietary needs described below. Parent Signature_____ Date_____

Part 2. Completed only by a licensed medical doctor (MD) or Nurse Practitioner treating the student

DIAGNOSIS_____

_

Does the child have an identified disability? Yes ☐ No ☐ If yes, please describe the major life activities affected by the disability _____

Indicate which dietary modification the student needs and ***specify*** what changes need to be made:

Circle all that apply:

Lactose intolerance: No Milk to Drink Avoid all dairy products Milk as Ingredient Substitute Lactose-free milk

Food Allergies? : (circle all that apply) Life Threatening Ingestion Contact Inhalation

Wheat Dairy Soy Peanuts Tree Nuts Egg Fish Shellfish

Other _____

Substitutions: _____

Printed Physician or Nurse Practitioner Name_____

Physician Signature _____

Telephone _____ Fax_____ Date _____

Allow two weeks for processing. We will contact you when we are prepared to provide special needs for your child.