



Director of Nutrition Services

District Nurse for Health Services

Date: August 2018

Dear Parent/Guardian:

As of the 2018-2019 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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For Special Nutritional Needs:
Annual Medical Statement for Students

Incomplete forms cannot be processed and will be returned to parent/ guardian

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 meals for your child.