Request for Special Dietary Accommodations

Every child is a work of art.
Create a masterpiece.

Suellen Pineda, MA, RDN, CDN
School Nutrition Coordinator

Dear Parent/Guardian:

We are pleased that_____, Date of Birth_____, will be participating in the National School Breakfast Program and/or National School Lunch Program in the Rochester City School District. We are prepared to offer modifications to our regular menu to accommodate conditions in which diet therapy is indicated. The U.S. Department of Agriculture requires that we have a signed diet prescription from a licensed medical authority.

All sections must be filled out in their entirety before the form is accepted.

Date: _____

Part I (To be completed by Parent/Guardian)

Name of Students (Last):_____(First):_____DOB:____/___/_____

School Attended:_____Grade:_____ID#:_____

School Nurse/ Nurse Consultant: _____

Contact Information: _____

I give Health Services / Food Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below and on the following page.

Parent/Guardian Signature Date: _____

Part II (To be completed by School Nurse or Physician) (Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such impairment, or is regarded as having such impairment.)

Does the child have a disability? Yes:_____ No:_____

Does the child have a life-threatening food allergy? Yes:_____ No:_____

Does the child have a food intolerance? Yes:_____ No:_____

If yes to any of the previous questions, Part III must be completed and signed by state licensed healthcare professionals, e.g., licensed physician (MD), physician assistant (PA), nurse practitioner (NP), or registered nurse (RN) and Registered Dietitians-nutritionist (RDN).

Part III Medical Diagnosis: _____

Foods to avoid:

_____All milk (dairy) protein due to **milk allergy** _____ Lactose intolerance

*If diagnosis of lactose intolerance, is the student able to tolerate small amounts of other lactose-containing foods such as cheese and yogurt? Yes: _____ No:_____

_____Peanuts _____Soy _____Crustacean-Shellfish

_____Tree-nuts _____Eggs _____Sesame

_____Wheat _____Corn

_____Gluten _____Fish

Other (**please be specific**) _____

Recommended substitutions: _____

Part IV Please provide a brief explanation of the effects of allergen exposure: _____

_____

_____

Name of Medical Authority (**please print):**_____

Signature:_____Date:_____

Phone: _____ Fax:_____

Mailing Address: _____

Send/give completed forms to the school nurse/nurse consultant at the child's school.

Any change of treatment must be requested in writing by the physician. To ensure that the request is processed prior to the first day of school, submit the request no later than one month prior to the first day of school.