Physician's Request for

Special Dietary Accommodations

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

Stefanie A. Mangefrida, RDN
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. Our meals are designed to provide one third of the recommended dietary allowances for major nutrients. 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 completely filled out before form will be accepted.

Date: _____

Part I (To be completed by Parent/Guardian)

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

School Attended: _____ Grade:_____ ID#:_____

Which meals will the child eat at school (please circle)? Breakfast / Lunch / After School Snack

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

If yes, please describe the major life activities affected by the disability: _____

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

If yes to any of the above questions, Part III must be completed and signed by a Licensed Physician. If no to both questions, Part III may be completed and signed by a Licensed Physician or Recognized Medical Authority.

Part III (To be completed by Licensed Physician or Recognized Medical Authority [i.e. Physician Assistant or Advanced Practice Nurse])

Medical Diagnosis: _____

Foods to be omitted:

_____Fluid Milk _____All dairy products ____All milk protein (casein, whey, etc.) _____Soy protein

_____Wheat _____Gluten _____Eggs _____All egg protein (albumin, etc.) _____Seafood

_____Corn (as major ingredient) _____All corn additives (dextrin, caramel color, etc.) _____Peanuts

_____All Nuts _____All foods produced in a facility with nut containing products

____ Other (please be specific) _____

Foods to be substituted: _____

(For non-disabled students who cannot have fluid milk, food services will choose the most appropriate milk substitute.)

Name of Medical Authority (please print):_____

Signature: _____ Date:_____

Phone: _____ Fax:_____

Mailing Address:

_____

Send/give completed forms to the school nurse/nurse consultant at your 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.

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