** Physician’s Request for**

**Special Dietary Accommodations**

David Brown

Director, School Food Services

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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_

School Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_ Student ID#:\_\_\_\_\_\_\_\_\_\_\_\_

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

School Nurse/ Nurse Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 completed forms to school nurse/nurse consultant.

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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