

# Medical Statement for Special Dietary Accommodations



All sections must be completely filled out before form will be accepted.

## Part I (To be completed by Parent/Guardian)

Name of Student (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

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

I give Health Services/ Nutrition Services permission to speak with the below named medical authority to discuss the dietary needs described below.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Part II (To be completed by State Recognized Medical Authority ONLY!)** Qualifying providers per HNS#11-2015 are: Dentists, Homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians.

Washington Elementary School District accommodates students with special dietary needs only in circumstances when the condition is deemed a physical or mental impairment that restricts the child's diet.

Please provide a description or explanation of how exposure to the food affects the child. **This must be filled out.**

### Foods to be omitted

☐ Wheat      ☐ Gluten      ☐ Eggs      ☐ All egg protein (albumin, etc.)      ☐ Sesame  
☐ Soy protein      ☐ Fluid Milk      ☐ Dairy products      ☐ All milk protein (casein, whey, etc.)  
☐ Fish      ☐ Shellfish      ☐ Peanuts      ☐ Tree Nuts

Other (please be specific): \_\_\_\_\_

Can the student be in a classroom with others consuming peanut butter? **Yes**      **No**

Foods to be substituted into the diet to accommodate dietary restriction:

Texture Modification: ☐ Soft & Bite Sized (6)      ☐ Minced & Moist (5)      ☐ Pureed (4)      ☐ other (specify)

### PLEASE MARK ONE:

**This diet order is:** ☐ **Permanent** (this diet order will remain in effect during the time the student is enrolled in WESD. A new diet order will be required to change any aspect of information provided in this diet order.)

**This diet order is:** ☐ **Temporary** (this diet order is effective for the current school year. A new form will be required annually.)

**Name of Medical Authority** (please print): \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

Send completed forms to dietitians in Nutrition Services. Fax: 602-896-5236, Email: [nicole.augustine@wesdschools.org](mailto:nicole.augustine@wesdschools.org)  
For questions or concerns call Nicole Augustine at 602-896-5240. Accommodations may take up to 10 business days to begin.

This institution is an equal opportunity provider.