24-25 School Year

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 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.