**MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY ACCOMMODATIONS**

# Requesting Dietary Accommodations in the U.S. Department of Agriculture (USDA) Child Nutrition Programs (National School Lunch Program, School Breakfast Program, Afterschool Snack Program, Summer Food Service Program)

**PART 1 TO BE COMPLETED BY PARENT/GUARDIAN. *PLEASE PRINT*.**

Child’s Name: Birth Date:

School Attended by Student: Grade: Student ID#:

Parent/Guardian Name:

Work Phone:

Home Phone:

Email:

 Yes  No

I give Nutrition Services permission to speak with the below named licensed healthcare professional to discuss the dietary needs. I understand that if I refuse to give permission, this will not impact the eligibility of my request for a special dietary accommodation for my child.

Parent/Guardian Signature:

**PART 2 TO BE COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL\***

*\*For purposes of Child Nutrition Programs, only a “Licensed Healthcare Professional” is permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs. The seven medical professionals listed are permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs administered in Arizona. (HNS# 11-2015).* ***Dentists****,* ***Homeopathic Physicians****,* ***Naturopathic Physicians****,* ***Nurse Practitioners****,* ***Osteopathic Physicians****,* ***Physician Assistants****, and* ***Physicians****.*

## Describe the patient’s physical or mental impairment that substantially limits one or more life activities (i.e. seeing, walking, speaking, learning, eating, breathing, etc.) and/or major bodily functions (immune system, digestive, bowel, bladder, etc.) and how it restricts the child’s diet.

1. **List foods/ingredients to be omitted from the diet.**
2. **List foods/ingredients that can be substituted into the diet to accommodate the dietary restriction.**

**This medical statement is:** **Permanent** *(This medical statement will remain in effect during the time the student is enrolled. A*

*new medical**statement will be required to change any aspect of information provided*

 *in this medical statement.)*

**This medical statement is:** **Temporary** *(This medical statement will remain in effect for the current school year. A new medical*

*statement will**be required annually.)*

Licensed Healthcare Professional Name: Office Phone Number:

Licensed Healthcare Professional Signature: Date:

**Return the completed form to AFUHSD Food Service Department.**

**For questions, contact Barbara Duncan @ 623-932-7009.**

# This institution is an equal opportunity provider.