Nazareth Area School District

Medical Statement for Students with Special Dietary Needs

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The school may choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).
- The school food authority may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations.

Student's Name: _____ **Age:**_____

School Name_____**Grade:**_____**Teacher/Team:**_____

Please check one of the following:

Does the student have a disability that requires the student to have a special diet? _____ Yes _____ No

If Yes, describe the disability and the major life activity affected by the disability. The form must be signed by a physician. Return it to the school when completed.

Describe the disability/diagnosis: _____

If student has life threatening allergies, please check when affected: ____ ingestion ____ contact ____ inhalation

If the student is NOT disabled, does he/she have a medically certified special dietary need? _____ Yes _____ No

If Yes, the form must be signed by a physician, physician assistant or nurse practitioner and returned to school.

List Special Diet or Dietary Restrictions: (please be specific regarding foods in their natural form vs. as an ingredient)

Food Allergies or intolerances: (list specific food(s) to be omitted):_____

List Allowable Food Substitutions:_____

Additional comments about the student's eating patterns or dietary modifications:

Parent/Guardian Name:_____**Phone:**_____

Medical Provider Name: _____**Phone:**_____

(Please print)

Medical Provider's Signature: _____ **Date:** _____

Original form to be kept in the student's health record and a copy given to Food Services. June 2011