Medical Request for Student Diet Modification

Washoe County School District
Nutrition Services

This form must be filled out completely and with the required signatures to be accepted.

A. PARENT/LEGAL GUARDIAN TO COMPLETE THIS SECTION

Student Name (Last, First): _____ **Birth Date:** _____

School Site: _____ **Student ID#:** _____

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

Please indicate which meals and how often your child will be needing a meal modification at school:

☐ Breakfast ONLY ☐ Lunch ONLY ☐ Breakfast & Lunch

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Monday—Friday (daily)

I authorize Washoe County School District Nutrition Services to provide the necessary diet accommodations for my child. I understand that it will be my responsibility to notify Nutrition Services of any changes to my child's dietary needs, including diet-related health changes, change of schools, and/or discontinuation of my child's modified meal service.

Signature: _____ **Date:** _____

B. LICENSED PHYSICIAN OR RECOGNIZED MEDICAL AUTHORITY* TO COMPLETE THIS SECTION

**Recognized Medical Authorities include: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN).*

Does the child have a disability? ☐ Yes ☐ No If yes, please describe below.

Does the child have a food allergy or intolerance? ☐ Yes ☐ No If yes, identify foods to be omitted below.

Please describe the child's physical or mental impairment and how it restricts the child's diet:

_____

Foods to be omitted from the child's meals (check all that apply):

☐ Fluid Milk ONLY ☐ All Dairy (including fluid milk) ☐ Soy ☐ Egg ☐ Wheat/Gluten

☐ Peanuts ☐ Tree Nuts ☐ Fish ☐ Shellfish

☐ Other(s): _____

Texture Modification (if needed):

List any foods that need the following texture modification(s). Indicate "All" if all foods need the indicated modification(s).

Bite Size Pieces: _____ Finely Chopped: _____ Pureed: _____

Other (please be specific): _____

Print Name & Title: _____

Medical Signature: _____ **Date:** _____

C. WCSD NUTRITION SERVICES OFFICE TO COMPLETE THIS SECTION

Date Received by Nutrition Services Office: _____ Initials: _____

Is additional clarification needed on the medical statement? _____Yes _____No. *If yes, please indicate follow up here:*

Initials: _____ Date: _____

Date discontinued: _____ *(attach documentation)*

ONCE COMPLETED, RETURN THIS FORM TO NUTRITION SERVICES VIA MAIL. Mailing Address: **585 Spice Islands Court, Sparks, NV 89431.**
Questions? Contact WCSD Nutrition Services at 775-325-8410, and ask for the Registered Dietitian.