

# Medical Request for Student Diet Modification



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.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, or call 1(866)632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact the USDA through the Federal Relay Service at 1(800)877-8339 or 1(800)845-6136 (Spanish). USDA is an equal opportunity provider and employer.