

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 OR EMAIL. Mail to: 585 Spice Islands Court, Sparks, NV 89431. Email to: Brielle.Zimmerman@WashoeSchools.net. Questions? Contact WCSD Nutrition Services Menu Planner, Brielle (Bristy) Zimmerman at 775-325-8438.

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