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: ___________________________

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.

A. List foods/ingredients to be omitted from the diet.

B. Provide a brief explanation of how exposure to the food affects the child.

C. 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 Mesa Public Schools Food and Nutrition Department
Fax: (480) 472-0992
For questions, please call 480-472-0900

For MPS internal use only  Copy to: _______ school nurse  _______ cafeteria manager  _______ F & N RDN

This institution is an equal opportunity provider.