

SPECIAL DIET STATEMENT for a Student *With* a Disability

This Special Diet Statement is ONLY for a student *with* a disability that affects the diet. This form must be:

- Thoroughly completed and signed by a licensed physician;
- Submitted to the school nurse who will share the form with the Food and Nutrition Services Manager at your child's school before any meal modifications will be made, and
- Updated whenever the student's diagnosis or special diet changes.

PART 1: STUDENT INFORMATION PARENT OR GUARDIAN MUST COMPLETE. PLEASE PRINT.	
Student's name: last/first/middle initial	Date of birth:
Parent/guardian name AND email address:	Work/home/cell phone numbers:
Parent/guardian name AND email address:	Work/home/cell phone numbers:
Name of school	Meals to be eaten at school: (check all that apply) breakfast lunch none

PART 2: STUDENT STATUS LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT.
<input type="checkbox"/> Student has a disability that restricts the student's diet. An individual with a disability is described under Rehabilitation Act (1973) and the American with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment.
<input type="checkbox"/> Has EpiPen
Identify the student's disability which restricts the student's diet: _____ _____
Identify the food(s) to be omitted due to the student's disability: _____ _____
Recommend alternate foods: _____

SIGNATURE OF LICENSED PHYSICIAN
Licensed physician name (print): _____
Signature: _____ Date: _____
Clinic name: _____
Phone #: _____ Fax #: _____

Please make arrangements each year to meet with the Food and Nutrition Services Manager at your child's school to complete and discuss the Special Nutrition Needs Form.