Information and Instruction Page | **Litchfield Elementary School District #79 Food & Nutrition Department** | **Special Dietary Needs Form**

The attached form is required for any menu substitutions or accommodations due to special dietary needs and must be completed and signed by a state licensed Healthcare Professional. Special diet requests can take 10-15 business days to process once the completed Special Dietary Needs Form has been received by the Food & Nutrition Office. If you do not want your child to receive a regular lunch during this time, please plan to send a lunch with your child until you have received verification from the district Nutritionist that your child's special diet has been reviewed and accommodations can be made. We cannot accept an allergy lab report in place of a state licensed Healthcare Professional's note. Additional Healthcare Professional notes may be submitted in addition to this form to the Food & Nutrition Department.

The Litchfield Elementary School District Food & Nutrition Department may make food substitutions, at their discretion, for individual children who are medically certified as having a special medical or dietary need. The LESD Food & Nutrition Department will try to accommodate any reasonable request for students without a certified medical or dietary needs. However, schools are not required to serve special meals to all children with diet restrictions (i.e. most food allergies/intolerances, such as wheat, citrus, egg, corn, lactose intolerance). Such determinations regarding dietary modifications will be made on a case-by-case basis by the LESD Food & Nutrition Department Nutritionist(s).

Instructions for Part I (to be completed by parent or guardian):

Name of Student: Enter the student's last and first name.
Date of Birth: Enter the student's eight-digit date of birth (i.e. March 31, 2002 = 03/31/2002)
School: Enter the name of the school that the student regularly attends.
Student ID #: Enter the student's school ID number (if known).
Parent/Guardian: Enter the full name of the student's parent(s) or legal guardian(s).
Phone Number: Enter the parent/guardian's daytime phone number with area code.
Email: If available, enter the primary email address for the parent/guardian.
Signature of Parent/Guardian: Enter the signature of one parent or legal guardian's name. A printed name on the previous line should correspond to the signature.

Instructions for Part II (to be completed by State Licensed Healthcare Professional):

Patient's Medical Condition: Please briefly describe the condition that requires dietary modifications.
Please explain how the Medical Condition restricts the diet and the major life activities: Describe how the patient's condition affects their diet (i.e. speaking, learning, working, etc.).
Does the child have a life-threatening food allergy? Indicate Yes or No.
If yes, has an EpiPen been prescribed? Indicate Yes or No.
Foods to be omitted: Please check the appropriate box (all that apply) to indicate which foods or food ingredients must be omitted from the student's diet.
Does the student need to sit at a peanut free table in the cafeteria? Indicate yes or no.
Foods to be used for substitution: Please indicate if there are any specific foods that should be used to replace the foods that are being omitted.
Please check: Please check the appropriate box for the child's condition – (life-threatening, managed by child with moderate supervision, or self-controlled by the child).
Diet request is permanent or temporary: Does the student have a permanent condition (i.e. celiac disease, anaphylactic food allergies, diabetes, etc.) or are the dietary modifications requested based on a temporary need to eliminate a food group (allergy testing, elimination diet trial, etc.).
Dietitian's Name (if available): Provide a dietitian's name and phone number if available.
State Licensed Healthcare Professional: Print the name, address, and phone number of the State Licensed Healthcare Professional completing the form.
State Licensed Healthcare Professional Signature: Enter the signature of the State Licensed Healthcare Professional filling out the form and the date signed.

Phone Number: (623) 535-6060
Fax Number: (623) 935-3398
Please Fax/Mail/or Scan and Email to: FOOD-NUTRITION@LESD.K12.AZ.US
Address: 18921 West Thomas Road, Litchfield Park, Arizona 85340

Received: _____

Medical Statement for Special Dietary Accommodations

LITCHFIELD ELEMENTARY SCHOOL DISTRICT

All sections must be completely filled out before the form is accepted. Accommodations may take up to 10-15 business days to begin.

Part I (*to be completed by parent or guardian*):

Student's Name: (*Last*) _____ (*First*)_____ **Date of Birth:** ____/____/____

School Attending: _____ **Grade:** _____ **Student ID #:** _____

Parent/Guardian Name: (*First and Last*) _____

Parent Contact Phone Number: ( ) _____ **Email:** _____

I give the Food & Nutrition Department permission to speak with the below named State Licensed Healthcare Professional to discuss the dietary needs described below.

Parent/Guardian Signature: _____ **Date:** _____

Part II (*to be **completed** by State Licensed Healthcare Professional*)

Medical Condition: _____

Does the medical condition restrict the student's diet? **Yes** **No**

If yes, explain how the condition restricts their diet: _____

Does the child have a life-threatening food allergy? **Yes** **No** **If yes, has an Epi-Pen been prescribed?** **Yes** **No**

Foods to be omitted (please mark all that apply)**:**

☐ Wheat	☐ Gluten	☐ Whole Eggs	☐ All egg protein (albumin, etc.)
☐ Soy protein	☐ Fluid milk	☐ All dairy products	☐ All milk protein (casein, whey, etc.)
☐ Peanuts	☐ All nuts	☐ Shellfish	☐ Fish
☐ Corn (as major ingredient)		☐ All corn additives (Dextrose, Dextrin, Caramel color, etc.)	

☐ Other (please be specific): _____

Does the student need to sit at a "Peanut Free" table in the cafeteria? **Yes** **No**

Foods to be used for substitution:_____

Please check: ☐ Life Threatening (needs close supervision) ☐ Managed by child with moderate supervision ☐ Self controlled by child

Texture Modification: ☐ Soft ☐ Minced/Ground ☐ Pureed ☐ Other (specify): _____

This diet request is: _____ Permanent (This diet request will remain in effect during the time the student is enrolled in LESD. A new diet request will be required to change any aspect of information provided in this request.)

This diet request is: _____ Temporary: Expiration Date:_____ (This diet request is effective until the expiration date or for the current school year. A new form will be required annually.)

Dietitian's Name (*if available)*: _____ Phone ( ) _____

State Licensed Healthcare Professional Information (please print):

Name: _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Mailing Address: _____

Please send completed form to Litchfield Elementary School District Food & Nutrition Office:
18921 W. Thomas Rd., Litchfield Park, AZ 85340
Fax: (623) 935-3398 **Email: FOOD-NUTRITION@LESD.K12.AZ.US** **Phone: (623) 535-6060**