CHILD NUTRITION DEPARTMENT STAFFORD MSD

PHYSICIAN STATEMENT

Form does NOT need to be renewed every year. Fill out new form only if dietary needs have changed. Send completed form to student's school nurse.

A. THIS SECTION TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Date _____ Student Name _____ ID Number _____ Date of Birth ___/___/___

School _____ Parent/Guardian _____ Phone Number _____

B. THIS SECTION TO BE COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL AUTHORIZED TO WRITE PRESCRIPTIONS

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a person with a disability is any person who has a physical or mental impairment that substantially limits one or more life activity, including food anaphylaxis.

1. Student's Medical Condition/Disability (REQUIRED): _____

2. Explain why the disability restricts the student's diet (REQUIRED): _____

3. Major life activity affected by the disability (eating, walking, seeing, hearing, breathing, learning/reading, speaking, performing manual tasks, caring for one's self, major bodily function) (REQUIRED): _____

4. List all food allergies: _____

5. Substitutions to serve in place of omitted food(s) (REQUIRED): _____

6. Texture Modification (*if applicable)*:

☐ Pureed ☐ Soft ☐ Chopped, specify size: _____ (ex. 1/4" bite-sized pieces)

☐ Other: _____

C. PHYSICIAN INFORMATIONS

Name of State Licensed Health Care Provider: _____

State Licensed Health Care Provider's Signature: _____

Clinic Name: _____ Phone Number: _____ Fax: _____

Changes to dietary treatment must be in writing by State licensed healthcare professional. Discontinuation of an accommodation for diet modification can be submitted in writing by State licensed healthcare professional or child's parent/guardian. Phone number must be included on parent's statement. Send statement to the student's school nurse.

Revised 8/31/2022