RICHLAND SCHOOL DISTRICT TWO

Medical Statement for Students Requiring Special Meals
Due to Food Allergy or Intolerance

Student Name: ______________________________ District: ________________________________

Birth Date: _________________________________ School: ________________________________

Parent Name: _______________________________ School Contact: _________________________

Address: ___________________________________ School Address: _________________________

Phone: ____________________________________ School Phone: __________________________

To be completed by a recognized medical authority (i.e. a licensed physician, physician's assistant, or nurse practitioner)

The school is not required to provide substitutions for an allergy or food intolerance, and is permitted to do so ONLY when omitted foods and appropriate substitutions are specified by a medical authority. If diet modifications are implemented by the school, they will continue until a medical authority specifies that they should be changed or stopped. Parents/guardians are asked to annually request updated instructions for diet modifications from a medical authority.

 A student has a disability affecting the diet that meets the definition of "disability" as described on the reverse
side of this form. If yes, complete Medical Statement for Student Requiring Special Meals Due to Disability.

Diet Prescription (check all that apply):

 Milk/Dairy Products Allergy – No fluid cow's milk or any other food product made with cow's milk such as cheese, yogurt, dried milk powder, etc. * * * If a student has an intolerance to milk and/or milk products, then please complete Form 21-G, Request to Omit Fluid Cow's Milk.

 Egg Allergy – No Eggs or Eggs as an ingredient in foods

Food allergies – Please check the appropriate box(es):

 ingestion
 contact
 inhalation

List the specific food(s) to be omitted and food(s) that may be substituted. If more space is needed for omitted foods or substitutions, please continue on the reverse side of the form. Specific foods to be omitted and specific foods to be substituted must be listed below or this statement will be returned to the physician/medical authority for clarification.

Meal Modification Start Date: _____________ End Date: _________________

Omit Foods Listed Below: **Substitute Foods Listed Below**

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Comments:

Physician/Medical Authority's Certification:
I certify that the student named on this form needs the prescribed food and/or beverage omission(s) and substitution(s) due to his/her food allergy (ies) and/or food intolerance(s).

____
Medical Authority's Printed Name

______________________________ ______________________________
Medical Authority's Signature Phone Number Date

______________________________ ______________________________
Preparer or Other Contact's Signature Phone Number Date

Parent/Guardian's Consent
I hereby permit the school staff to make the prescribed food and/or beverage omission(s) and substitution(s) in my child's school meals. Furthermore, should the school staff require additional information to clarify how to carry out the diet prescription or food omissions and substitutions; I hereby permit my child's physician/medical authority to provide any additional information necessary to clarify the diet prescription written on this form.

______________________________ ______________________ ___________
Parent/Guardian's Signature Phone Number Date