Updated March 8th, 2022

State Licensed Healthcare Professional Request for Special Dietary Accommodations

All sections must be completely filled out before form will be accepted.

Part I: To be completed by Parent/Guardian

Name of Student (Last): _____ (First): _____ Date of Birth: ___/___/____ School Attended: _____ Grade:_____ Student ID#:_____ Which meals will the child eat at school (please circle) Breakfast /Lunch /After School Snack

Parent/Guardian: _____ Phone Number: _____ Email: _____ I give Health Services/ Nutrition Services permission to speak with the below named Physician to discuss the dietary needs described below.

Parent/Guardian Signature _____Date: _____

Part II: To be completed by a 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.**

Description of child's physical or mental impairment: _____ _____

_____

Does the medical condition impact a major bodily function or other major life activity (such as digestion, respiration, immune response, skin, rash, etc.). **Yes** **No**

If you answered yes to the above question, Part III must be completed and signed by a state licensed healthcare professional. If no to the questions, accommodations are not required to be made through nutrition services, Part III is not necessary.

You may request an appeal if your child was denied diet modification by contacting the Section 504 Coordinator (school nurse.)

____Fluid Milk ____ All dairy products ____ All milk protein (casein, whey, etc.) _____ Lactose

____ Soy protein ____ Wheat ____ Gluten ____ Eggs ____ All egg protein (albumin, etc.)

____ Seafood ____Shell Fish ____ Corn (as major ingredient)

____ All corn additives (dextrin, caramel color, etc.) ____ Peanuts ____ All Nuts

___All foods produced in a facility with nut containing products ____Other (please be specific)

Foods to be substituted:_____ _____

Texture Modification: ____ soft ____ minced ____ pureed other (specify) _____

This diet order is: ____ Permanent (this diet order will remain in effect during the time the student is enrolled in HUSD.

A new diet order or written documentation from the child's guardian will be required to change any aspect of information provided in this diet order.)

This diet order is: _____ Temporary (this diet order is effective for the current school year. A new form will be required annually.)

Licensed Healthcare Professional Name:_____

Office Phone Number:_____

Licensed Healthcare Professional Signature:_____

Date:_____

Send completed forms to
HUSD Child Nutrition Attention Pamela Liuzzo, Nutritionist
6411 North Robert Road. Building 200
Prescott Valley, AZ 86314
Fax: 928-759-5042, Email: Pamela.liuzzo@humboldtunified.com
Questions 928-759-5017
Accommodations may take up to 10 business days to begin.
This institution is an equal opportunity provider.