MEDICAL STATEMENT FOR STUDENTS WITH ALLERGIES, CHRONIC ILLNESS OR DISABILITY WHO REQUIRES SPECIAL DIETARY ACCOMMODATIONS

Student's Name_____ Date of Birth_____ Date_____

Parent/Guardian_____

Phone_____ Additional Phone_____

* West Fargo Public Schools will make food accommodations for this student **only** when provided with this physician's statement specifying the reason for the accommodation.

PHYSICIAN STATEMENT FOR STUDENTS REQUIRING FOOD ACCOMMODATIONS

Under section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment or is regarded as having such an impairment. The term physical impairment includes many conditions such as, Diabetes, Celiac disease and food anaphylaxis (severe food allergy).

*Does this student have a disability that restricts his/her diet? (please circle) **YES / NO**

*If ***YES***, describe the disability. (i.e. Celiac Disease, allergy to peanuts, etc.)_____

*Describe how this disability restricts the diet and affects a major life activity (i.e. eating, learning, breathing, caring for one's self, etc.)_____

*Is there a **Life Threatening/Anaphylactic Food Allergy?** (please circle) **YES / NO**

___**Food Allergy** (check below) *all foods containing allergen to be avoided*

◯ Wheat ◯ Egg ◯ Soy

◯ Peanut ◯ Tree Nut ◯ Fish and Shellfish

◯ Milk (including all dairy) ◯ Other (specify) _____

____**Diabetes**

____**Texture Modification** (please specify)_____

____**Other** (please specify)_____

____**Lactose Intolerance** (lactose-reduced milk is available)

Physician's Signature_____ Date_____

Parent's Signature_____ Date _____

This institution is an equal opportunity provider.

___Food Service