FORT WAYNE COMMUNITY SCHOOLS
1200 South Clinton Street
Fort Wayne, IN 46802

NUTRITION SERVICES
3211 W. Ludwig Rd.
Fort Wayne, IN 46818

Statement for Students with Special Dietary Needs in Child Nutrition Programs

Dear Parents/Guardians:

A medical statement is required for students whose disabilities restrict their diets. Please have your physician complete the Physician Section of this form. If your student has a milk disability or allergy, please complete the Milk Substitution Section of this form. Return the completed form to the school nurse, who will share it with FWCS Nutrition Services Registered Dietitians.

Student Name: _____ DOB:_____

School: _____ Grade:_____

Guardian Name: _____ Phone:_____

*I have reviewed and understand the information provided by my child's physician. I agree that it will be placed on file as a part of my child's school health record and will be shared with appropriate district and school staff. I understand that FWCS Nutrition Services Registered Dietitians are permitted to contact my child's physician to obtain further explanation of the above information. This authorization is in force for the **2023-24** school year unless I submit new information in writing to the school.*

Signature of Parent/Guardian: _____

Telephone number: _____ Date: _____

Physician Section:

Does the student have a disability (physical or mental impairment) that requires the student to have a special diet?

☐ Yes ☐ No

If yes, check the disability (System) and list the major life activity affected by the disability.

☐ Immune System ☐ Neurological ☐ Respiratory ☐ Circulatory ☐ Endocrine
☐ Normal Cell Growth ☐ Digestive ☐ Bowel/Bladder ☐ Brain ☐ Reproductive

_____

Describe the reason for the special dietary need (food allergy, lactose intolerance, etc.).

Diet Prescription (List food(s) to be omitted or recommended alternatives). *Food preferences are not an appropriate use of this form.*

☐ I agree that FWCS Registered Dietitians may make appropriate recommendations for food substitutions.

Signature of Physician: _____
Please Print Physician name: _____
Telephone number: _____ Date: _____

This institution is an equal opportunity provider.

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Milk Substitution Section:

Does the student have a milk disability (physical or mental impairment) or allergy that requires the student to have a milk substitute?

☐ Yes ☐ No

Explain why the student needs a milk substitute.

_____

_____

Appropriate substitutions:

_____

_____

Are yogurt and cheese acceptable? ☐ Yes ☐ No

Is milk as an ingredient acceptable? ☐ Yes ☐ No

☐ I agree that FWCS Registered Dietitians may make appropriate recommendations for food substitutions.

Signature of Parent/Guardian: _____

Print Parent/Guardian name: _____

Telephone number: _____ Email: _____Date: _____