Michelle Philipp
Director of Nutrition Services
219-374-3921
mphilipp@hanover.k12.in.us

HANOVER COMMUNITY SCHOOL CORPORATION
9520 W. 133rd AVENUE, CEDAR LAKE, INDIANA 46303

Katie Donaghue
Director of Health Services
219-374-3862
kdonaghue@hanover.k12.in.us

For Special Nutritional Needs:
Annual Medical Statement for Students

Part 1. To be filled out completely by parent or guardian ⇨

Student's Full Name, please print

Last_____ First_____ Middle _____

Date of Birth _____Age_____Student ID# _____

School _____Grade_____School Year_____to_____

Will your student eat breakfast at school? ☐ Yes ☐ No Lunch at School? Yes ☐ No ☐

Parent/Guardian Name, please print _____

Daytime telephone number/cell _____ E-mail

_____

Mailing Address_____City_____State_____Zip_____

I give Nutrition Services permission to speak with the below-named physician or authorized medical authority to discuss the dietary needs described below. Parent Signature_____Date_____

Part 2. Completed only by a licensed medical doctor (MD) or Nurse Practitioner treating the student

DIAGNOSIS_____

Does the child have an identified disability? Yes ☐ No ☐ If yes, please describe the major life activities affected by the disability _____

Indicate which dietary modification the student needs and ***specify*** what changes need to be made:

Circle all that apply:

Lactose intolerance: ☐ No Milk to Drink ☐ Avoid all dairy products ☐ Milk as Ingredient ☐ Substitute Lactose-free milk

Food Allergies? : (circle all that apply) ☐ Life Threatening ☐ Ingestion ☐ Contact ☐ Inhalation

☐ Wheat ☐ Dairy ☐ Soy ☐ Peanuts ☐ Tree Nuts ☐ Egg ☐ Fish ☐ Shellfish ☐ Sesame

Other _____

Substitutions: _____

Printed Physician or Nurse Practitioner Name_____

Physician Signature _____

Telephone _____ Fax_____ Date _____

Allow two weeks for processing. We will contact you when we are prepared to provide special needs for your child.