SY 2023-2024

Deer Valley Unified School District

Physician Request for Special Diet Accommodations

All sections must be complete before the form will be accepted. Accommodations may take up to 10 days to begin.

Part I (To be filled out by parent/guardian)

Name of Student: ***(Last)*** _____ ***(First)***_____**ID#**_____

Date of Birth: _____/_____/_____ **Grade:** _____ **School**: _____

Which meals will the child eat at school (please circle all that apply): Breakfast Lunch

Parent/Guardian:_____ **Phone**: _____

Email:_____

Signature of Parent/Guardian: _____ **Date**: _____

I give the Food & Nutrition Department permission to speak with the below named Physician to discuss the dietary needs described below.

Part II (To be filled out by licensed physician- **M.D. or D.O. only**)

Patient's Diagnosis:_____

Is the medical condition a disability that restricts the student's diet?: Yes No

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has record of such impairment or is regarded as having such impairment.

If yes, explain how the disability restricts their diet and the major life activities affected by the disability:

_____

Does the child have a life-threatening food allergy?: Y N If yes, has an EpiPen been prescribed? Y N

If yes to any of the above questions, Part III must be completed and signed by a **licensed physician**. If no was answered to the first two questions, accommodations are not required to be made by the Food & Nutrition Department and Part III is not necessary.

Part III (To be filled out by licensed physician-- **M.D. or D.O. only**)

Foods to be omitted: *PLEASE READ CAREFULLY & CHECK APPROPRIATE BOX*

Dairy
□ ALL dairy proteins (casein/whey/etc: Includes dairy in pancakes, bread, etc)
□ ALL dairy product (Includes: cheese, yogurt, smoothies, pizza, tacos, etc)
□ Fluid milk ONLY (All other dairy OK)
Milk Alternatives: □ Lactose Free milk □ Fortified Soy "Milk"

Eggs
□ ALL egg protein (includes egg in baked goods, breaded chicken, etc)
□ Whole egg ONLY (Scrambled, Hard boiled, Egg Sandwich, etc)

Seafood
□ Fish
□ Shellfish

Nuts
□ Peanuts
□ Tree nuts

Gluten
□ Gluten (Wheat, Rye, Barley)

Soy Protein
□ Soy protein

Sesame
□ Sesame

□ Other (Please be specific):_____

Does food texture need to be modified? Y N □Soft □Minced □Pureed □ Other (Specify) _____

Diet Request is: ____**Permanent** (Diet request will remain in effect during the time the student is continuously enrolled in DVUSD. A new diet request will be required to change any aspect of the information provided in this request.)

Diet Request is: ____**Temporary** (Diet request is effective for the current school year. A new form will be required annually.)

Dietitian's Name *(if available)*: _____ Phone ( ) _____–_____
Name of Licensed Physician: (Please Print) _____
Physician Signature _____ Date _____
Phone: _____ Fax: _____
Mailing Address: _____

Send completed request to: Fax: 623-445-5167 or Email: nutrition@dvusd.org. For questions call: 623-445-5165

This institution is an equal opportunity provider. Updated: 4/21/23

Request for Special Diet Accommodation Instructions

PURPOSE: To record the student's condition requiring dietary modifications of school breakfast and/or lunch and the changes needed to accommodate the student's condition.

PREPARATION: The parent or guardian of the child is responsible for obtaining the form, filling out Part I, requesting completion of Parts II and III by a licensed physician (M.D. or D.O.), and delivering the complete form **to the kitchen manager at the school where the child attends or by faxing the form to the district dietitian.** Consultation by a dietitian for completion of the form, if needed, should be requested by the parent or physician.

Instructions for Part I **(to be filled out by parent or guardian):**

- **Name of Student**: Enter the student's last name and first name.
- **ID#**: Enter the student's school ID number.
- **Date of Birth**: Enter the student's six-digit date of birth, e.g., May 21, 2017 = 05/21/17.
- **School**: Enter the name of the school which the student regularly attends.
- **Parent/Guardian**: Enter the full name of the student's parent(s) or legal guardian(s).
- **Phone Number**: If available, enter one or two telephone numbers with the area code where one or two of the guardians can be reached during the daytime.
- **Email**: If available, enter the primary email address for the parent/guardian.
- **Signature of Parent/Guardian**: Enter the signature of one parent or legal guardian's name. A printed name on the previous line should correspond to the signature.

Instructions for Part II **(to be filled out by Physician-M.D. or D.O. only):**

- **Patient's Diagnosis**: Insert the patient's clinical diagnosis for the condition which requires dietary modification.
- **Is the medical condition a disability?:** Indicate if the above medical diagnosis is considered a disability based on the definition set out in Section 504 of the *Rehabilitation Act of* 1973, the *Americans with Disabilities Act* of 1990 and the *Individuals with Disabilities Education Act* (IDEA).
- **If yes, please explain how the disability restricts the diet and the major life activities affected by the disability:** Describe the patient's condition as it affects a major life activity (i.e. caring for one's self, walking, seeing, speaking, learning, working, etc). Describe how the restrictions of the patient's condition affect his or her diet.
- **Does the child have a life-threatening food allergy?:** Indicate Y (yes) or N (no)
- **If yes, has an EpiPen been prescribed?** Indicate Y (yes) or N (no)

Instructions for Part III **(to be filled out by Physician-M.D. or D.O. only):**

- **Foods to be omitted:** Please READ CAREFULLY & CHECK APPROPRIATE BOX.
    - Check the appropriate box(s) to indicate which foods or food ingredients must be omitted from the student's diet.
    - There are three options for dairy:
        - Fluid Milk (acceptable milk substitutes must be listed)
        - All Dairy Products-such as cheese, yogurt, and products containing these items such as pizza and tacos.
        - All Milk Protein-such as casein & whey and includes products containing any dairy protein such as pancakes & breads.
    - There are two options for Egg. Please read carefully.
- **Does food texture need to be modified?:** Indicate Y (yes) or N (no). If yes, check box to indicate how texture should be modified.
- **Diet request is permanent or temporary**: Does the student have a permanent disability (i.e. celiac disease, anaphylactic food allergies, etc.) or are the dietary modifications requested based on a temporary need to eliminate a food group (allergy testing, elimination diet trial, etc.).
    - A temporary request will require a new SDA Form at the beginning of each school year.
- **Dietitian's Name (if available)**: Provide a dietitian's name and phone number if available.
- **Physician**: Print the name, address and phone number of the licensed physician (M.D. or D.O. only) completing the form.
    - MUST be legible and verifiable
- **Physician Signature**: Enter the signature of the physician filling out the form and the date signed.