BUCKEYE
ELEMENTARY SCHOOL DISTRICT #33
A community passionate about student success

25555 W Durango Street
Buckeye AZ, 85326
• Phone 623-925-3400
• Fax 623-386-6063
• http://besd33.org

Bales Elementary
25400 W Maricopa Road
P: 623-847-8503
F: 623-327-0744

Buckeye Elementary
211 South 7th Street
P: 623-386-4487
F: 623-386-7901

Inca Elementary
23601 W Durango Street
P: 623-925-3500
F: 623-386-4690

Jasinski Elementary
4280 S 246th Avenue
P: 623-925-3100
F: 623-327-2708

JSM Elementary
3170 S 247th Ave
P:623-866-6200

Marionneaux Elementary
24155 W. Roeser Road
P: 623-866-6000

Sundance Elementary
23800 W Hadley Street
P: 623-847-8531
F: 623-386-6049

WestPark Elementary
2700 S 257th Drive
P: 623-435-3282
F: 623-386-3398

BESD Preschool
604 Centre Avenue
P: 623-925-3333
F: 623-386-6219

Medical Statement for Students with Special Dietary Needs SY 2024-2025

Please note: **An updated form will be required at the beginning of each school year.**
This form is required for any menu substitutions or accommodations do to special dietary needs. Special diet requests can take 2-3 weeks to process. Please send a lunch or breakfast with your child until you receive verification that your child's special diet request has been reviewed and accommodations can be made. *Incomplete forms will be returned.*

Part 1 (*filled out by parent/guardian*):

Student Full Name: ______________________________

Date of Birth: ______________ Current Age: __________ Grade: __________

School Attending: ______________ Homeroom Teacher: __________

Parent/Guardian Full Name: ______________________________

Phone Number: ______________ Email: ______________________

Part 1a (Diagnosis paper work attached)

If diagnosis paper work is attached from recognized medical authority, stop here no need for **Part 2** below.

Parent/Guardian Signature must be obtained here to comply with **Part 1a.**

Parent/Guardian Signature: ______________________________ Date: __________

Part 2 (*filled out by Physician*):

- This portion of the form must be signed by a **recognized medical authority** (physician, physician authority, nurse practitioner…)

Medical Diagnosis / Food Allergy / Chronic Disease, requiring diet modification: ______________________________

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Check the following regarding the child's medical condition:

☐ Life Threatening ☐ Anaphylactic Allergy

☐ Managed by child with moderate supervisio ☐ Self-Controlled by child

Foods to be Omitted:	**Suggested Foods for Substitution:**
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________

Medical Authority Name (*print*): ______________________ Phone: ______________

Medical Authority Signature: ______________________ Date: ______________

Once completed return to Child Nutrition Department and School Health Assistant