LAWNDALE
Elementary School District

Nutrition and Wellness Services
4161 W. 147th Street || Lawndale, CA 90260
Ph. 310.973.1300 Fax 310.675.3955
lawndalesd.net||@LESDschools

Parent Notification Letter for Special Meal Accommodation

Dear Parent/Guardian,

If your child has a food allergy or otherwise requires a special meal accommodation, please complete the following attached form. We are proud to follow state and federal laws to make reasonable accommodations for students with disabilities, including those with dietary restrictions.

The attached Letter to Medical Professionals and Medical Statement to Request Special Meals and/or Accommodations **must** be signed by a licensed medical professional, such as a licensed physician, physician assistant, or nurse practitioner. The form can also be signed by a Registered Dietitian. Electronic signatures from a licensed medical professional and/or dietitian are acceptable. Be sure to complete the Student Information Section prior to giving these documents to your provider. Your medical provider should complete the Medical Information section. Instead of completing the attached form, your medical provider may provide us the information requested on their own letterhead. If we have any questions about the information shared on the form, we may call you or the provider for clarification.

Once the documentation has been completed, please return it to the Health Clerk at your child's school. You can do this by dropping it off at the school's main office. The Health Clerk will log this information in your child's health file and will share this with Nutrition and Wellness Services. Please note that up to 10 business days may be needed to process the request and begin the accommodation.

If in the future your child's food allergies and/or other dietary restrictions change, please let us know **as soon as possible.** You can do this by contacting the Health Clerk at your child's school. We will need to submit a new meal accommodation form or a form advising that meal accommodations are no longer needed.

If you have any questions regarding meal accommodations, please contact Iza Diosdado, Nutrition Operations Manager at 310-973-1300 ext. 50049.

Sincerely,

Lissette Rooney, Director
Nutrition and Wellness Services

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Carta de Notificación a los Padres sobre Alergias de Alimentos o Adaptación de Comidas

Estimado Padre/Guardián:

Si tienes un hijo/a que tiene alergias alimentarias o necesita otras adaptaciones alimentarias, favor de completar los documentos que siguen. Nosotros seguimos leyes estatales y federales para proveer acomodaciones razonables para estudiantes discapacitados, incluyendo restricciones alimentarias.

Los documentos que siguen, la Carta a Proveedores Médicos y la Declaración Médica para la Solicitud de Comidas Especiales y Adaptaciones **necesitan** tener la firma de un médico con licencia, un asistente médico (Physician Assistant) o una enfermera practicante (Nurse Practitioner). En adición, el documento puede ser firmado por una nutricionista titulada, también conocida como un Registered Dietitian en inglés. Firmas electrónicas son aceptadas.

Favor de completar la sección titulada "Student Information Section" antes de dar se lo a su proveedor médico. Ellos deben de completar la sección titulada "Medical Information." Sí preferido, el proveedor médico puede comunicar todos los datos que hemos pedido en su propia forma. Si tenemos cualquier pregunta sobre la información, nos comunicaremos con usted o con el proveedor.

Cuando los formularios han sido completados, favor de regresarlo al Health Clerk (Asistente de salud) en la escuela de tu hijo/a. Puedes dejarlos documentos en la oficina en la escuela de su hijo/a. El Health Clerk (asistente de salud) va ingresar estos datos en el sistema de salud para su hijo/a y comunicar esos documentos al departamento de Servicios de Nutrición y Bienestar. Favor de tomar en cuenta que hay posibilidad que nos tomará hasta 10 días de trabajo para procesar los documentos y empezar la adaptación.

Si en el futuro las alergias u otras restricciones dietéticas cambian para su hijo, favor de avisarnos **tan pronto como sea posible.** Puedes comunicarte con el Health Clerk (Assistente de salud) en la escuela de tu hijo/a. En este caso, necesitaremos que se regrese un nuevo formulario o un formulario avisando que ya no hay necesidad de adaptaciones de comidas.

Si tienes cualquier pregunta sobre las adaptaciones de comidas, favor de comunicarse con Iza Diosdado, Nutrition Operations Manager al 310-973-1300 ext. 50049.

Atentamente,

Lissette Rooney, Directora
Servicios de Nutrición y Bienestar

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USDA Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
fax:
(833) 256-1665 or (202) 690-7442; or
email:
Program.Intake@usda.gov

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PARENTAL REQUEST FOR A FLUID MILK SUBSTITUTION FOR SCHOOL-AGE CHILDREN

1. Name of School Food Authority	2. Name of School Site	3. Site Telephone Number
4. Name of Student		5. Age or Date of Birth
6. Name of Parent/Legal Guardian		7. Telephone Number ( )

8. The above listed student does not have a disability, but is requesting a fluid milk substitute due to a medical or other special dietary need. This form is not intended to accommodate students who drink fluid milk substitutions such as soy milk due to taste preferences. The School Food Authority has the discretion to select a specific brand of milk substitute since acceptable products must meet specified nutrient requirements. Juice cannot be offered as a fluid milk substitute for students with medical or special dietary needs that **do not** rise to the level of a disability.

This written statement will remain in effect until the parent or legal guardian revokes such statement or until the school discontinues the fluid milk substitution option. School districts and agencies participating in federal nutrition programs are encouraged, but not required, to accommodate reasonable requests. **The student's parent or legal guardian must sign this form.**

9. Medical or other special dietary need requiring a fluid milk substitution:

10. Signature of Parent/Legal Guardian	11. Printed Name of Parent/Guardian	12. Date

Please note: When necessary, the information on this form should be updated to reflect the current medical and/or nutritional needs of the student.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

SOLICITUD DE LOS PADRES PARA LA SUSTITUCIÓN DE LECHE LÍQUIDA

1. Nombre de la Autoridad Alimentaria Escolar	2. Nombre de la Escuela	3. Número de Teléfono Escolar
4. Nombre del Estudiante		5. Edad o Fecha de Nacimiento
6. Nombre del Padre o Tutor Legal		7. Número de Teléfono ( )

8. El estudiante enumerado anteriormente no tiene discapacidad, pero está solicitando un sustituto de leche líquida debido a una necesidad médica o necesidad dietética especial. El propósito de esta solicitud no es el de proveer acomodación a estudiantes quienes beben sustitutos de leche líquida, como la leche de soya, debido a preferencia personal. La Autoridad Alimentaria Escolar reserva el derecho, a su sola discreción, el seleccionar ciertas marcas de sustitutos de leche líquida ya que los productos aceptables deben de cumplir con los requisitos específicos de nutrientes. El jugo no puede ser ofrecido como un sustituto de leche líquida para estudiantes con necesidades médicas o necesidades dietéticas especiales que **no** surgen al nivel de discapacidad.
Esta declaración por escrito permanecerá en vigor hasta que el Padre o Tutor Legal revoque esta declaración o hasta que la escuela suspenda la opción de sustitución de leche líquida. Se recomienda a los distritos escolares la opción de sustitución de leche líquida. Se recomienda a los distritos escolares y agencias participantes en el Programa Federal de Nutrición, pero no es necesario, hacer adaptaciones razonables. **Los Padres o Tutores Legales del estudiante deben firmar esta solicitud.**

9. Necesidad Médica u Otra Necesidad Dietética Especial que requiere sustitución de leche líquida:

10. Firma de Padre/Tutor Legal	11. Escriba en Letra de Molde el Nombre de Padre/Tutor Legal	12. Fecha

Tenga en Cuenta: Cuando sea necesario, la información de esta solicitud debe actualizarse para reflejar la condición actual médica o necesidad dietética especial del estudiante.

El Departamento de Agricultura de Estados Unidos prohíbe la discriminación en contra de sus clientes, empleados y solicitantes de empleo sobre la base de raza, color, origen nacional, edad, discapacidad, sexo, identidad de género, la religión, las represalias y donde, creencias políticas, estado civil aplicable, estado civil o paternal, orientación sexual, o la totalidad o parte de los ingresos de un individuo se deriva de cualquier programa de asistencia pública, o información genética protegida en el empleo o en cualquier programa o actividad realizada o financiada por el Departamento. (No todas las bases prohibidas se aplican a todos los programas y/o actividades de empleo.

Si desea presentar una queja al Programa de Derechos Civiles de discriminación, completar el Formulario de Quejas de Discriminación del Programa de USDA, que se encuentra en línea en http://www.ascr.usda.gov/complaint presentación cust.html, o en cualquier oficina de USDA, o llame al (866) 632-9992 para solicitar el formulario. También puede escribir una carta que contenga toda la información solicitada en el formulario. Envíenos su formulario de queja o una carta por correo al Departament of Agriculture, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410, o por fax al (202) 690-7442 o por correo electrónico a program.intake@usda.gov. Las personas sordas, con problemas de audición o discapacidades del habla pueden comunicarse con USDA por medio del Servicio Federal de Retransmisión al (800) 877-8339; o, (800) 845-6136 (español).

USDA es un proveedor y empleador que ofrece igualdad de oportunidades.

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Letter to Medical Professional | **Medical Statement for Special Meal Accommodations**

Dear Medical Professional,

Lawndale Elementary School District operates a federally funded Child Nutrition Program where we feed students nourishing meals each school day. We are proud to follow state and federal laws that require us to make reasonable accommodations for students with disabilities, including those with dietary restrictions. Providing us with key information permits us to safely accommodate this student while adhering to government policies and funding guidelines. To best serve the student, please provide the following in writing:

- The food(s) and beverage(s) to be avoided
- Provide a brief explanation of how exposure to the food affects the student and restricts their diet
- Recommended substitutes

You can easily provide the requested information by completing the **Medical Statement to Request Special Meals and/or Accommodations form,** attached. We also ask:

- **Be specific**. Please be as detailed as possible when listing safe substitutions.
- **Sign it.** This form requires a signature from an authorized, state-licensed medical authority* such as a Physician, Physician Assistant, or Nurse Practitioner. Registered Dietitians may also sign.
- **Provide your contact information.** Please provide us with your office's contact information so that we may call you in case of any questions upon reviewing the form.

Please return the completed and signed Medical Statement form to the parent or guardian of the child. They will then submit the completed form to the Health Clerk at their child's school. If you would prefer, you may indicate answers to all the questions on the attached form on your letterhead, complete with a signature.

If you have any questions in regards to this form, please reach out to Iza Diosdado, Nutrition Operations Manager with Lawndale Elementary School District's Nutrition and Wellness Services Department at 310-973-1300 x. 50049 or via email at iza_diosdado@lawndalesd.net.

We look forward to working with you to provide safe and delicious meals to this student.

Sincerely,

Lissette Rooney
Director, Nutrition & Wellness
lissette_rooney@lawndalesd.net

*If requesting lactose-free or soy milk, a written request from a parent/guardian may be accepted. For all other dietary requests, the USDA requires signatures from a state-licensed medical authority.

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MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Complete this form only if you are **requesting special meals/and or accommodations from the school cafeteria**. Please note that this request will remain in effect during the time the student is enrolled at Lawndale Elementary School District. A new request in writing will be required to change the information provided below. This form may be updated regularly to reflect the current medical and/or nutritional needs of the student.

Student Information/*Informacion estudiantil* - Completed by parent or guardian/*Completado por padre o guardian*

School/*Escuela*	Grade/*Grado*	Student ID #/*# de estudiante*
Student Name/*Nombre de estudiante*	Date of Birth/*Fecha de nacimiento*	
Parent or Guardian Name/*Nombre de padre o guardian*	Phone #/*Numero de telefono*	

Which meal(s) need accommodation? (mark all that apply) ¿Cuáles comidas necesitan adaptaciones?	How often will the student eat school meals? (mark one) *¿Con qué frecuencia va a comer comida de la cafetería escolar?*
☐ Breakfast/Desayuno ☐ Lunch/Almuerzo ☐ Afterschool Meals/*Comidas despues de la escuela*	☐ Daily *Diario* ☐ Weekly *Cada semana* ☐ Occasionally *De vez en cuando* ☐ Rarely *Raramente*

Medical Information - Completed by State Licensed Healthcare Professional*/Completado por proveedores médicos

*A licensed physician, a physician assistant, or nurse practitioner. Registered Dietitians may also sign.

Description of student physical or mental impairment affected:	Explain the diet prescription and/or dietary accommodation:
Food Texture Modification (if applicable, select one only)	☐ Pureed ☐ Ground ☐ Chopped

Foods & Beverages To Be Omitted (mark all that apply)

- Fluid **Milk only**
- **Dairy** products (milk, cheese, yogurt, Ranch, etc.)
- **Egg** (including mayonnaise)
- **Soy** (edamame, soy sauce, tofu, soy butter, etc.)
- **Peanuts**
- **Tree Nuts** (almonds, coconut, walnuts, etc.)
- **Fish** (pollock, tuna, Caesar dressing, fish sauce, etc.)
- **Shellfish**
- **Sesame** (tahini, sesame oil, etc.)
- **Wheat**
- **Gluten** (including wheat, barley, and rye)
- **Other**, please list:

____

Suggested Substitutions (mark all that apply and/or use "Other" to be as specific and descriptive as possible)

- **Milk** in baked/cooked foods is ok
- **Cheese** in cooked foods is ok
- **Egg** in baked foods is ok
- **Soy** oil in cooked foods is ok

Other ____

____

____

____

____

⚠ BEFORE SIGNING, PLEASE ENSURE THAT ALL SECTIONS ARE COMPLETE.

X ____

*Signature of State Licensed Healthcare Professional or Registered Dietitian (Required)

Printed Name ____

Phone #______________________ Date _____ /_____ /_____

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INSTRUCTIONS

Student and Family Information *(to be filled out by parent or legal guardian)*

School Site Name: Print the name of the school that the student regularly attends.

Name of Student: Print the first and last name of the student to whom the information pertains.

Date of Birth: Print the student's six-digit date of birth, e.g., May 21, 2015 = 05/21/15.

Student ID #: Enter the student's ID number, if known.

Name of Parent or Guardian: Print the first and last name of the student's parent or legal guardian requesting the child or participant's medical statement.

Parent/Guardian Phone Number: Enter the 10-digit phone number of the parent or guardian.

Which meals will the student eat at school: Circle all the meals that the student will be getting from the cafeteria. If the student does not plan on eating any meals from the cafeteria, leave this section blank.

How often will the student eat at school: Indicate how often the student will be eating food from the cafeteria (example: daily). If the student does not plan on eating any meals from the cafeteria, leave this section blank.

Medical Information *(to be filled out by State Recognized State Licensed Healthcare Professional)*

Description of Child or Participant's Physical or Mental Impairment Affected: Describe how the physical or mental impairment restricts the student or participant's diet.

Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation: Describe a specific diet or accommodation that has been prescribed by the State Recognized Licensed Healthcare Professional.

Texture Modification: If the student does not need any modification, check "Regular".

Foods to be Omitted or Avoided: Check or circle the food(s) that must be omitted or avoided (e.g., exclude fluid milk).

Foods/beverages that can be used as a substitute: State which specific food(s) and/or beverage(s) substitutions, if any, must be made related to the medical condition or food allergy (e.g., soy milk).

Name of State Licensed Healthcare Professional: Print name of State Licensed Healthcare Professional.

State Licensed Healthcare Professional's Signature: Signature of State Licensed Healthcare Professional requesting the meal accommodation.

Phone: Enter the 10-digit phone number of a State Licensed Healthcare Professional.

Date: Enter the date State Licensed Healthcare Professional signed form.

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DEFINITIONS

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

Physical or mental impairment means, any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disability.

Physical or mental impairment includes, but is not limited to, contagious and noncontagious diseases and conditions such as the following: orthopedic, visual, speech, and hearing impairments, and cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional illness, dyslexia and other specific learning disabilities, Attention Deficit Hyperactivity Disorder, Human Immunodeficiency Virus infection (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working; and the operation of a major bodily function.

Major bodily function includes*,* the operation and functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems. The operation of a major bodily function includes the operation of an individual organ within a body system.

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Allergies/Anaphylaxis Physician Orders and Student Health Plan

Name of Student ____ Date of Birth ______________ Grade _______
Parent/Guardian _______________________________________ Phone ________________ Phone____________
Emergency Contact __________________________________ Relationship ________________ Phone ___________

Parent/Guardian Authorization: I authorize LESD to administer the prescribed medication ordered by my health care provider. I will provide the medication and equipment in the original pharmacy-labeled container. I approve the health plan as written**. Signature of parent/guardian:**____

HEALTH CARE PROVIDER TO COMPLETE ALL SECTIONS BELOW

Student is allergic to: ____

Medication Ordered for Anaphylaxis

- ☐ Epinephrine Injectable 0.3 mg
- ☐ Epinephrine Injectable 0.15 mg
- ☐ Other med ______________________
- ☐ Student needs assistance with epinephrine
- ☐ Student has been instructed by me and may be allowed to self-carry and self-administer epinephrine

Antihistamine ordered for Mild allergic reaction

- ☐ Diphenhydramine (AKA Benadryl)
- ☐ Other med ________________________
- ☐ Student needs assistance with antihistamine
- ☐ Student has been instructed by me and may be allowed to self-carry and self-administer antihistamine.

MILD ALLERGIC REACTION

Requires MD order: Name of antihistamine ________________ Dose ________________

If symptoms worsen, give Epinephrine

ANAPHYLAXIS

ANAPHYLAXIS—DO THIS

1. Stop physical activity
2. **Inject Epinephrine immediately.**
3. Call 9-1-1 and tell dispatcher student has Anaphylaxis and epinephrine was given.
4. Notify school nurse and parent.
5. Stay with student. Lay student flat, elevate legs, and keep warm.
6. If breathing is difficult, or student is vomiting, may allow to sit up or turn on side.
7. If symptoms do not improve, or if symptoms return, **give a second dose of epinephrine after 5 minutes**.

Physician Name:______________________________________ Signature: _______________________________
Address: ____ Phone: __________________________________

(Physician stamp acceptable)