



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 2025-2026

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: _____

Check the following regarding the child's medical condition:

- | | |
|--|---|
| <input type="checkbox"/> Life Threatening | <input type="checkbox"/> Anaphylactic Allergy |
| <input type="checkbox"/> Managed by child with moderate supervisio | <input type="checkbox"/> 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

This institution is an equal opportunity provider.