

Medical Statement for Special Dietary Accommodations

Scottsdale Unified School District Nutrition Services

Please fill out this form completely.



Part I (To be completed by Parent/Guardian)

Student ID#: _____

Name of Student (Last): _____ (First): _____

Date of Birth: ____/____/____ School Attending: _____ Grade: _____

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

Parent/Guardian: (First & Last) _____

Phone Number: () _____ Email: _____

Parent/Guardian Signature _____ Date: _____

In order for your child to have their school meal modified or substituted, please have a State Recognized Medical Authority fill out this section in full.

Part II (To be completed by a State Recognized Medical Authority only)

Food Allergy (please be specific): _____

Please provide a brief description of how ingestion, contact, inhalation and/or exposure to the food affects the child:

Does the child have a life-threatening food allergy? Yes No If yes, has an Epi-Pen been prescribed? Yes No

Name of Medical Authority (please print): _____

Medical Authority's Signature: _____

Date: _____ Phone: _____

Mailing Address:

Send completed forms to Nutrition Services. If any changes occur to the child's diet, please update the Nutrition Services Department immediately. A new form is required. For questions, please contact Nutrition Services. Send completed form to the Scottsdale Unified School District Child Nutrition Services via email. Phone: 480-484-6211 Email: claszczak@susd.org

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This institution is an equal opportunity provider.