

Request for Special Dietary Accommodations

All sections must be completely filled out before form will be accepted.

Part I: To be completed by Parent/Guardian

Name of Student (Last): _____ (First): _____ Date of Birth: ___/___/___

School Attended: _____ Grade: _____ Student ID#: _____

Which meals will the child eat at school (please circle)? Breakfast /Lunch /After School Snack

Parent/Guardian: _____ Phone Number: _____ Email: _____

I give Health Services/Nutrition Services permission to speak with the below named Physician to discuss the dietary needs described below. Parent/Guardian Signature _____ Date: _____

Part II: To be completed by a State Licensed Healthcare Professional or Registered Dietitian*

*For purposes of Child Nutrition Programs, only a "Licensed Healthcare Professional or Registered Dietitian" is permitted to complete and sign a medical statement for meal accommodations in Child Nutrition Programs. The seven medical professionals listed are permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs administered in Arizona. (HNS# 11-2016). **Dentists, Homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians. Registered Dietitians can also sign this form.**

Description of child's physical or mental impairment: _____

Does the medical condition impact a major bodily function or other major life activity (such as digestion, respiration, immune response, skin, rash, etc.) **Yes No** If you answered yes to the above question, Part III must be completed and signed by a state licensed healthcare professional. If no to the questions, accommodations are not required to be made through nutrition services, Part III is not necessary. You may request an appeal if your child was denied diet modification by contacting the Section 504 Coordinator (school nurse).

Part III: To be completed by a State Licensed Healthcare Professional

___ Fluid Milk ___ All dairy products ___ All milk protein (casein, whey, etc.) ___ Lactose

___ Soy protein ___ Wheat ___ Gluten ___ Eggs ___ All egg protein (albumin, etc.)

___ Seafood ___ Shell Fish ___ Corn (as major ingredient)

___ All corn additives (dextrin, caramel color, etc.) ___ Peanuts ___ All Nuts

___ All foods produced in a facility with nut containing products ___ Other (please be specific)

Foods to be substituted: _____

Texture Modification: ___ soft ___ minced ___ pureed other (specify) _____

This diet order is: ___ Permanent (Will remain in effect during the time the student is enrolled in HUSD. A new diet order or written documentation from the child's guardian will be required to change any information provided in this diet order).

This diet order is: ___ Temporary (This diet order is effective for the current school year. A new form will be required annually.)

Name of state licensed healthcare professional (**please print**): _____

Signature: _____ Date: _____ Phone _____ Fax: _____

Mailing Address _____

Send completed forms to HUSD Child Nutrition:

6901 Panther Path, Room 128, Prescott Valley, AZ 86314

Email: amanda.garfield@humboldtunified.com

Questions: 928-759-5017, Fax: 928-759-5042

Accommodations may take up to 10 business days to begin