



Food and Nutrition Services

# MEDICAL FORM FOR STUDENTS WITH SPECIAL DIETARY NEEDS

**The Special Dietary Needs form is exclusively for use in the WCPS National School Breakfast, Lunch and Dinner programs administered by the Department of Food and Nutrition.**

*Should your child require special medical consideration for a condition unrelated to dietary needs, please contact your child's school nurse.*

**This WCPS Food & Nutrition form should be completed and turned into your child's school health room if:**

Your child is new to  
WCPS and has a  
special dietary need

OR

Your child develops a  
special dietary need  
that has not been  
requested/reported  
in the past

OR

Your child's  
special dietary  
needs change

# INSTRUCTION TO COMPLETE THE WCPS MEDICAL FORM FOR STUDENTS WITH SPECIAL DIETARY NEEDS

Revised 7/2025

- **Forms do not need to be submitted each year** - once a form has been submitted, the information will follow a student from year to year.
- **Another form should be submitted only if there is a change to a student's special dietary need.**
- **Parents/Guardians** – You only need to complete **PART 1**
- **Physicians or Registered Dietitian (RD)** – Only complete **PART II** if the student requires a special diet that is classified as a disability or medically identifies a specific food allergy. *(Any information completed in Section II without a physician's signature and phone number will be disregarded.)*

When food allergies exist, or when water, juice or almond milk is required in place of fluid milk due to a disability, **PART II** of this form must be completed by a physician or Registered Dietitian indicating:

- The student has an identified disability that requires him/her to have a special diet, and the specific foods that are to be omitted and/or included as part of a prescribed special diet
- If a disability exists, the major life activities affected by the disability
- If a food allergy exists, if it is life threatening
- The specific food to which an allergy exists and appropriate substitutions
- The completed form should be turned in to your child's school health room.

## PLEASE NOTE REGARDING MILK

WCPS will provide soy milk or lactaid in place of regular milk at a parents/guardians request *(see Part I below)*.  
**A Doctors note is not required for a soy/lactaid substitution due to an intolerance or allergy.**

In order for a student to receive water, *juice or almond milk* in place of fluid milk in the National School Breakfast/Lunch programs, a physician must diagnose a student's diet restriction as a **disability** and provide all required information under **PART II** of this form.

Under Federal School Breakfast/Lunch regulations, **an intolerance or allergy is not a disability.**

# WCPS MEDICAL FORM FOR STUDENTS WITH SPECIAL DIETARY NEEDS 7/2025

USDA regulations require a signed medical statement from a recognized medical authority in order for the cafeteria to make substitutions for students with a life-threatening food allergy, disability, or medical condition that requires a special menu or substitution.

## PART I: TO BE COMPLETED BY A PARENT/GUARDIAN IF A SPECIAL DIETARY NEED EXISTS

Student's Name:	Grade	Student ID:	Birth Date:
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<input type="checkbox"/> Due to specific special dietary needs, my child will not eat school provided meals	<input type="checkbox"/> Lactose Intolerance: Instead of milk please provide my child with: <input type="checkbox"/> soy milk <input type="checkbox"/> lactaid
<input type="checkbox"/> Please provide my child with a vegetarian menu <input type="checkbox"/> Please provide my child with a vegan menu	<input type="checkbox"/> My child <b>had</b> a food allergy or intolerance but no longer does. Please remove all restrictions.

For religious reasons please do not allow my child to have the following foods:

- My child has a food intolerance to:  
 Please assist my child to ensure they make appropriate food selections that omit the following:

I give Food and Nutrition Services and or the school nurse permission to speak with the below named physician or Authorized Medical Authority to discuss the dietary needs described in Part II:  YES  NO

\_\_\_\_\_  
Parent/Guardian Name Printed

\_\_\_\_\_  
Parent/Guardian Signature & Date

**PARENTS/GUARDIANS: DO NOT WRITE BELOW**

## PART II: TO BE COMPLETED ONLY BY A PHYSICIAN, RD OR HEALTH CARE PROVIDER

Does the child have an identified disability that requires him/her to have a special diet?  YES  NO  
 If yes, please describe the major life activities affected by the disability:

Does the child have a life threatening food allergy?  YES  NO

FOOD ALLERGIES: Check appropriate box(es):  Ingestion  Contact  Inhalation

<input type="checkbox"/> milk	<input type="checkbox"/> wheat	<input type="checkbox"/> soy	<input type="checkbox"/> peanuts	<input type="checkbox"/> tree nuts
<input type="checkbox"/> fish	<input type="checkbox"/> shellfish	<input type="checkbox"/> whole eggs	<input type="checkbox"/> egg as an ingredient	<input type="checkbox"/> gluten
<input type="checkbox"/> sesame	<input type="checkbox"/> other (please be specific):			

Physician Office Phone #:

Physician Office Fax #:

\_\_\_\_\_  
Physician/RD Name Printed

\_\_\_\_\_  
Physician/RD Signature & Date

**Return completed form to your child's School Health Room**