



Every child is a work of art.
Create a masterpiece.

Request for Special Dietary Accommodations

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School Nutrition Coordinator

Dear Parent/Guardian:

We are pleased that _____, Date of Birth _____, will be participating in the National School Breakfast Program and/or National School Lunch Program in the Rochester City School District. We are prepared to offer modifications to our regular menu to accommodate conditions in which diet therapy is indicated. The U.S. Department of Agriculture requires that we have a signed diet prescription from a licensed medical authority.

All sections must be filled out in their entirety before the form is accepted.

Date: _____

Part I (To be completed by Parent/Guardian)

Name of Students (Last): _____ (First): _____ DOB: ____/____/____

School Attended: _____ Grade: _____ ID#: _____

School Nurse/ Nurse Consultant: _____

Contact Information: _____

I give Health Services / Food Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below and on the following page.

Parent/Guardian Signature Date: _____

Part II (To be completed by School Nurse or Physician) (Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" is any person who has a physical or mental impairment that substantially limits one or more life activities, has a record of such impairment, or is regarded as having such impairment.)

Does the child have a disability? Yes: _____ No: _____

Does the child have a life-threatening food allergy? Yes: _____ No: _____

Does the child have a food intolerance or sensitivity? Yes: _____ No: _____

If yes to any of the previous questions, Part III must be completed and signed by state licensed healthcare professionals, e.g., licensed physician (MD), physician assistant (PA), nurse practitioner (NP), or state credentialed nutrition healthcare practitioner or Registered Dietitians-nutritionist (RDN).

Part III Medical Diagnosis: _____

Foods to avoid:

_____ All milk (dairy) protein due to **milk allergy** _____ Regular milk due to **lactose intolerance**

*If diagnosis of lactose intolerance, is the student able to tolerate small amounts of other lactose-containing

foods such as cheese and yogurt? Yes: _____ No: _____

_____ Peanuts _____ Soy _____ Crustacean-Shellfish

_____ Tree-nuts _____ Eggs _____ Sesame

_____ Wheat _____ Corn

_____ Gluten _____ Fish

Other (**please be specific**) _____

Recommended substitutions: _____

Part IV Please provide a brief explanation of the effects of allergen exposure: _____

Name of Medical Authority (**please print**): _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

Mailing Address: _____

Send/give completed forms to the school nurse/nurse consultant at the child's school. Any change of treatment must be requested in writing by the physician. To ensure that the request is processed prior to the first day of school, submit the request no later than one month prior to the first day of school.