

**MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS**
☐ **New Request** ☐ **Change/Modify Existing Request** ☐ **Discontinue Request**
PART 1: GENERAL INFORMATION - COMPLETED BY THE PARENT/GUARDIAN

I understand as a parent, that it is my duty to update this form **any time there is a change or discontinuation of dietary needs** and to give to the school nurse. I give Broward County Public Schools FNS permission to speak with the state licensed healthcare professional to discuss dietary needs as ordered.

X _____
PARENT/GUARDIAN SIGNATURE DATE CONTACT NUMBER OF PARENT/GUARDIAN

Student First and Last Name

State licensed healthcare professional may assist parent/guardian in completing this section.

Student Date of Birth

Lactose Intolerance☐ No Yogurt due to Lactose Intolerance☐ No Cheese due to Lactose Intolerance☐ No Fluid Dairy Milk due to Lactose IntoleranceOffer instead: ☐ Lactose Free Cow's Milk ☐ Water ☐ Soy Milk

Name of School/Center

Name of Parent/Guardian

PART 2: ALLERGIES - COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL**Section A: Student with Medical Disability/Life-Threatening****Section B: Student with NO Medical Disability/Non-Life-Threatening**

Does the student have a disability which restricts the student's diet? ☐ Yes* ☐ No

***If Yes**, describe or state the student's **disability** or **diagnosis**. Explain why it restricts the student's diet and list major life activities affected by the disability: _____

Food Allergy: Student has food allergies that **ARE** life threatening/anaphylactic: ☐ Yes, continue with this section.
☐ No, refer to section B.

Student has allergies/intolerances that are NOT life-threatening/anaphylactic:

Milk/Dairy Allergy: Check **ALL** that apply. ☐ No Fluid Dairy Milk
☐ No Yogurt ☐ No Cheese ☐ No menu items with milk as an ingredient - - Substitute with ☐ Soy Milk ☐ Water

Egg Allergy: Check **ALL** that apply. ☐ No Whole Eggs (such as scrambled or boiled) ☐ No menu items with egg as an ingredient

☐ **Soy Allergy** (soy oil is allowed)

Additional Food Allergies: (Please print) _____

Milk/Dairy Allergy: Check **ALL** that apply. ☐ No Fluid Dairy Milk
☐ No Yogurt ☐ No Cheese ☐ No menu items with milk as an ingredient - - Substitute with ☐ Soy Milk ☐ Water

Egg Allergy: Check **ALL** that apply. ☐ No Whole Eggs (such as scrambled or boiled) ☐ No menu items with egg as an ingredient

☐ **Soy Allergy** (soy oil is allowed)Additional Food Allergies: (Please print) _____Indicate Food Texture for Above Student: ☐ Regular ☐ Pureed**PART 3: SIGNATURE – COMPLETED BY A LICENSED MEDICAL PROFESSIONAL**

Printed Name of State Licensed Medical Professional

Title:

☐ Physician☐ Physician Assistant☐ Nurse Practitioner (ARNP)☐ Registered Dietitian/ Nutritionist

Signature of State Licensed Medical Professional

Date Signed

VALID FOR ONE YEAR FROM THIS DATE

Medical Office Address

Medical Office Phone Number



MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

The parent or guardian must complete Part 1. **A state licensed healthcare professional** who is authorized to write medical prescriptions under state law must complete **Parts 2 and 3**. In Florida, this includes a Physician, Physician's Assistant, or Nurse Practitioner (ARNP).

PART 1: GENERAL INFORMATION - COMPLETED BY THE PARENT/GUARDIAN

1. **Parent/Guardian Signature:** Read responsibility statement. Then, sign, date, and print phone number of the parent/guardian requesting the student/participant's special meal and/or accommodation.
2. **Student First and Last Name:** Print the name of the student that is asking a special meal and/or accommodation.
3. **Date of Birth:** Print the date the student was born.
4. **Name of School/Center:** Print the name of the location where the student will eat.
5. **Name of Parent or Guardian:** Print the name of the person who signed the responsibility statement.
6. **Lactose Intolerance:** Check all lactose containing foods that the student cannot have. Be sure to also check a drink that the student *can* have.

PART 2: ALLERGIES - COMPLETED BY A STATE LICENSED HEALTHCARE PROFESSIONAL

Section A: Complete this section if Student has a Medical Disability that IS Life Threatening

7. **Does the student have a disability:** Check Yes or No.
 - a. "Student with a disability" is defined as any student who has a **physical or mental impairment** that substantially limits one or more **major life activities**, has a record of such impairment, or is regarded as having such an **impairment**.
 - b. "A physical or mental impairment is" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genitourinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.
 - c. "Major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.
 - d. "Has a record of such an impairment" is defined as having a history of or has been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.
8. **Disability/Diagnosis:** Describe or state the student's disability or diagnosis and explain why it restricts the student's diet and list major life activities affected by the disability.
9. **Food Allergy:** Check Yes or No to indicate if student has a life-threatening food allergy. If yes, continue with Section A. If no, go to Section B.
10. **Milk/Dairy Allergy:** Check all foods that the student cannot have. Check a drink that the student/participant can have.
11. **Egg Allergy:** Check all foods that the student cannot have.
12. **Soy Allergy:** Check if applicable.
13. **Additional Food Allergies:** Print additional life-threatening food allergen(s) that the student is allergic to (e.g. Peanut, Tree Nut, Wheat, Fish, Shellfish, Sesame).
14. **Indicate Texture:** If the student or participant does not need any modification, check "Regular"

Section B: Complete this Section if Student does NOT have a Medical Disability/Non-Life-Threatening Food Allergy/Intolerance.

15. **Milk/Dairy Allergy:** Check all foods that the student cannot have. Check a drink that the student can have.
16. **Egg Allergy:** Check all foods that the student cannot have.
17. **Soy Allergy:** Check if applicable.
18. **Additional Food Allergies:** Print additional non-life-threatening food allergen(s) that the student is allergic/intolerant to (e.g. Peanut, Tree Nut, Wheat, Fish, Shellfish, Sesame).

PART 3:

19. **Printed Name State licensed medical professional's name:** Print the name of the state licensed medical professional who oversees the care of the student.
20. **Title:** Check the box that describes the licensed medical professional's credentials.
21. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
22. **Date signed:** The date state licensed healthcare professional signed form.
23. **Medical Office Name:** Print the name of the office where the student receives care from the state licensed medical professional.
24. **Medical Office Address:** Address of state licensed medical professional's office / place of work.
25. **Medical Office Phone Number:** The phone number of the state licensed healthcare professional.