AVONDALE
Elementary School District

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

PART 1 (To be completed by parent or guardian)

1. School	2. Student ID #	3. Birthdate
4. Name of Child		5. Grade Level
6. Name of Parent or Guardian		7. Phone Number

_____ _____

Signature of parent or guardian **Date**

8. Indicate the meals/days your child eats in the school cafeteria:

Breakfast

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **None**

Lunch

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **None**

This medical statement is:_____Permanent *(This medical statement will remain in effect during the time the student is enrolled. A new medical statement will be required to change any aspect of information provided in this medical statement.)*

This medical statement is:____Temporary *(This medical statement will remain in effect for the current school year. A new medical statement will be required annually.)*

PART 2 (To be completed by licensed healthcare professional*)

9. Patient's physical or mental impairment that restricts the child's diet:
10. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation: (Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification)

11. Indicate food texture for above child:
(If participant does not need any modification, check "regular".)

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

12. Foods to be Omitted and Appropriate Substitutions:
(Attach additional sheets if needed)

Foods To Be Omitted	Suggested Substitutions

13. Adaptive Equipment to be Used:

14. Signature of State Licensed Healthcare Professional*	15. Printed Name	16. Phone Number	17. Date

***For this purpose, a licensed healthcare professional may be a licensed physician, a physician assistant, a nurse practitioner, dentist, homeopathic physician, naturopathic physician, osteopathic physician (HNS# 11-2015).**

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