# Parent Information Packet: Food Restriction or Special Needs Diet Documentation Requested

To the parent of _____ Date: _____

While reviewing the *Student Health History Form* you completed for your child, it was noted you indicate he/she may have a medical condition requiring a special needs diet (list special dietary need): _____

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special medical diet, food substitution, and/or observation for this condition at school.

Please complete the section below and return to me at school, with appropriate documentation as requested. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

_____
School Health Staff

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Please check the box next to the most appropriate statement for your child, sign the bottom of this page and return to the school health office.

____ This is not a health concern.
____ My child does have the following condition/diagnosis _____ which requires a special dietary needs (Describe)

_____

_____

PLEASE PROVIDE THE FOLLOWING DOCUMENTS **ANNUALLY** TO THE SCHOOL HEALTH OFFICE:

- ☑ **Medical Statement for Student with Food Allergy, Food Restriction or Special Needs Diet** form signed by an **Arizona Licensed Physician/Health Care Provider** (provide once and update as needed). If this form is NOT submitted to the School Health Office, then the cafeteria can NOT make accommodations for your child.
- ☑ **Please see school health staff if your child requires medications to be given at school.**

_____ _____ _____
Name of Parent and/or Guardian Signature Date

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# MEDICAL STATEMENT FOR STUDENT WITH FOOD ALLERGY, FOOD RESTRICTION OR SPECIAL NEEDS DIET

(Upon Registration and/or New or changed diagnosis. Update Anytime Food Allergy, Food Restriction, or Special Needs Diet Changes)

**PART 1: To be completed by a Parent or Guardian:**

Name of Student: _____ Date of Birth _____ Gender: M F
School: _____Grade: _____ Teacher _____
Name of parents/guardians: _____
Home Phone: _____Work Phone: _____Cell: _____

**PART 2: To be completed and signed by an Arizona Licensed Physician/Health Care Provider**

**Patient Diagnosis**:_____

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification:_____
**Food Allergies or Intolerances**:_____

**Are any of these Food Allergies potentially Life Threatening for this student?** Yes No
(If Yes, Complete the "Food Allergy Action Plan" and consider prescribing multiple EpiPens (for home, school health office, and to be stored in the classroom or carried by the student as age appropriate) or other necessary medications as needed.
**Which Food(s) may be life threatening**: _____

**Food Substitutions:** _____

**Indicate which dietary modification the patient needs (if any) and specify what changes need to be made**:

____ Texture Modification:
- ____ Pureed
- ____ Ground
- ____ Chopped
- ____ Other _____
- ____ Specify Foods _____

____ Nutrient Modification
- ____ Increase calories Description_____
- ____ Supplement Name _____
- ____ Decrease calories Description _____
- ____ Nutrient Restriction Description _____

____ Special Mealtime Equipment: _____

____ Other: _____
Dietician Name and Phone Number (if applicable): _____

**Arizona Licensed Physician/Healthcare Provider Signature** authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

**Provider's Printed Name** _____ **Phone:** _____

**Provider's Signature:** _____ **Date:** _____