PARENT REQUEST FORM

Name of Student: (Last) _____ (First) _____ (Middle) ____

Date of Birth _____ Student ID # _____ School _____ Grade _____

Will student eat breakfast provided by the school cafeteria?	Will student eat lunch provided by the school cafeteria?	Will the student eat a snack provided by the After School Snack Program?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Printed Name of Parent/Guardian: _____

Mailing Address: _____ City: _____ State/Zip: _____

Phone number(s): _____ (Work) _____ (Home) _____ (Cell)

Email Address: _____

Do you have concerns about your child's nutritional needs at school?

☐ Yes ☐ No

Please describe: _____

Do you have concerns about your child's ability to safely participate in mealtime at school (i.e., swallowing difficulties or life-threatening allergies)?

☐ Yes ☐ No

Please describe: _____

Has your child ever received a medical diagnosis that would necessitate modification of school meals?

☐ Yes ☐ No

Please list the diagnosis, if any: _____

My child requires the following:

☐ Change in food texture ☐ Modification of calorie intake ☐ Fluid milk substitution

☐ Food omissions and substitutions ☐ Meal pattern modification/number of meals

☐ Other

Please describe: _____

Does your child have an Individualized Education Program (IEP) or 504 Plan?

☐ Yes ☐ No

Has your child ever been determined to have a disability?

☐ Yes ☐ No Explain: _____

Parent/Guardian Signature: _____ Date: _____

Parental/Guardian Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and have provided the attached signed release form.

Parent/Guardian Signature: _____ Date: _____

MEDICAL STATEMENT

Licensed Physician or Recognized Medical Authority:

This form helps schools provide meal modifications for students who require them. Completion of all items will streamline efficient care of the student.

- In the case of students with disabilities, the District needs a statement from the child's licensed physician to modify a student's diet at school.
- In the case of students with special dietary needs but without a disability, the District needs a statement from a recognized medical authority, such as a physician, nurse practitioner, or physician's assistant.

Meal modifications are implemented based on medical assessment and treatment planning of a licensed physician or recognized medical authority.

Name of Student: (Last) _____ (First) _____ (Middle) ____

Date of Birth _____ Student ID # _____ School _____ Grade _____

Student Diagnosis/Impairment/Condition:

Manner in which diagnosis/impairment restricts diet:

Is a Major Life Activity affected by the student's diagnosis or impairment? Mark if appropriate:

☐ Caring for	☐ Breathing	☐ Bending
☐ Performing manual tasks	☐ Learning	☐ Reading
☐ Walking	☐ Working	☐ Concentrating
☐ Seeing	☐ Sleeping	☐ Thinking
☐ Hearing	☐ Standing	☐ Communicating
☐ Speaking	☐ Eating	

☐ Other: _____

☐ Major Bodily Function (Circle all that apply: Immune system, Normal cell growth, Digestive, Bowel, Bladder, Neurological, Brain, Respiratory, Circulatory, Reproductive, or Endocrine).

Specify any dietary restrictions or special diet instructions for school meals:

Designate consistency requirements for food:

☐ No change needed	☐ Blenderized liquid
☐ Clear Liquid	☐ Pureed
☐ Full liquid	☐ Mechanical soft
	☐ Other: _____

Designate consistency requirement for liquids:

☐ No change needed	☐ Honey-like
☐ Thin	☐ Spoon-thick
☐ Nectar-like	☐ Pudding-thick
	☐ Other: _____

ALLERGIES OR INTOLERANCE

The child has food *intolerance* to the following foods, which should be avoided:

_____

_____

The child has food *allergies* to the following foods:

_____ ☐ ingestion ☐ contact ☐ inhalation

_____ ☐ ingestion ☐ contact ☐ inhalation

_____ ☐ ingestion ☐ contact ☐ inhalation

If yes, does the student have **life threatening** allergies* to any of the foods listed above that would result in severe reactions, such as anaphylactic shock? ☐ Yes ☐ No

Please list which foods trigger life-threatening allergies:

_____

_____

Does the child use an Epipen for the food allergies listed above? ☐ Yes ☐ No

* Students with life threatening food allergies must have an emergency action plan in place at school.

For *any* special diet, list specific foods to be omitted and substitutions; you may attach a separate care plan.

a. Foods To Be Omitted	b. Recommended Substitutions

Please describe other nutritional, feeding, or dietary issues:

_____

I certify that the student named on this form needs the prescribed meal modifications, omissions, or substitutions due to his/her disability or other medical needs.

Signature of Licensed Physician or Medical Authority*	Printed Name	Phone Number	Date

*For students with disabilities, USDA regulations require a statement from a licensed physician in order to modify school meals.

Parental/Guardian Consent: I have reviewed the recommendations provided above by my child's health care provider regarding my child's school meals.

Parent/Guardian Signature: _____ Date:_____

Parental/Guardian Release: I agree to allow my child's health care provider and school personnel to discuss information on this form and have provided the attached signed release form.

Parent/Guardian Signature: _____ Date:_____