

Special Dietary Needs | Revised April 2020 | Arizona Department of Education | This institution is an equal opportunity provider.

Arizona **Department of Education**
Health and Nutrition Services

Medical Statement for Students with Special Dietary Accommodations

This form is used **to** request Dietary Accommodations in the U.S. Department of Agriculture (USDA) Child Nutrition Programs such as the National School Lunch Program, School Breakfast Program, Afterschool Snack Program, and Summer Food Service Program. Send completed forms to **Beaver Creek School**. For any questions, please contact **Karen Dufresne** at **928-567-4631**.

Part 1: To be completed by a parent/guardian

Child's Name:

School Name:

Birth **Date**:

Child's Grade:

Parent/Guardian Name:

Cell Phone:

Email:

Parent/Guardian Signature:

Work Phone:

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Part 2: To be completed by state licensed healthcare professionals'

*For purposes of Child **Nutrition Programs**, only a "Licensed Healthcare Professional" is permitted to complete and sign a medical statement for meal accommodations in the **Child Nutrition Programs**. The seven medical professionals listed are permitted to complete **and** sign a medical statement for meal accommodations in **the Child Nutrition Programs administered in Arizona**. (HNS# **11-2015**). Dentists, Homeopathic Physicians, **Naturopathic** Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, **and** Physicians.

A. List **of** foods/ingredients to be omitted from the diet.

B. Provide **a** brief explanation of how exposure to the food affects the child.

C. List of foods/ingredients that can be substituted into the diet to accommodate the dietary restrictions.

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)

Licensed Healthcare Professional Name:

Office Phone Number:

Licensed Healthcare Professional Signature:

Date: