Medical Statement for Students with Special Dietary Accommodations

Arizona Department of Education Health and Nutrition Services

Part I (to be filled out by parent or guardian)

Name of Student: *(Last)*__________________*(First)*________________ Date of Birth:____/____/____

School Attended by Student____

Grade:_____ Student ID#:__________ Which meals will the child eat at school? Breakfast ____ Lunch_____

Name of Parent/Guardian(s) ____

Parent/Guardian(s) Daytime Phone Number(s) (   )_____-_______(   )_____-_______

Signature of Parent/Guardian(s) ____

Part II (to be filled out by State Licensed Healthcare Professional)

Patient's Diagnosis and/or Medical Condition:____

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification:

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Indicate the necessary dietary modification:

Foods and/or ingredients to **AVOID:**	Diet prescription accommodation/substitution:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Texture Modification: Pureed________ Ground_______ Chopped _______ Other_____________

Licensed Healthcare Professional Printed Name____

Address ______________________________________ Phone Number (____) ______-________

Licensed Healthcare Professional's Signature ____

NOTE:
In Arizona, a state licensed healthcare professional authorized to write medical prescriptions can sign this medical statement. These individuals include: Dentists, homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians.