

# MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY ACCOMMODATIONS

Requesting Dietary Accommodations in the U.S. Department of Agriculture (USDA) Child Nutrition Programs (National School Lunch Program, School Breakfast Program, Afterschool Snack Program, Summer Food Service Program)

## PART 1 TO BE COMPLETED BY PARENT/GUARDIAN. PLEASE PRINT.

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School Attended by Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

## PART 2 TO BE COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL\*

*\*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 foods/ingredients to be omitted from the diet.**

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

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

**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: \_\_\_\_\_

Return the completed form to **Nutrition Services Director** at 480-461-0556, [rgomezacosta@concordiacharter.org](mailto:rgomezacosta@concordiacharter.org).  
For questions, contact **Mrs. Acosta** at 480-461-0555, [rgomezacosta@concordiacharter.org](mailto:rgomezacosta@concordiacharter.org).

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