

**MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS**
☐ **New Request** ☐ **Change/Modify Existing Request** ☐ **Discontinue Request**

PART 1: GENERAL INFORMATION - COMPLETED BY THE PARENT/GUARDIAN			
I understand as a parent, that it is my duty to update this form <u>any time there is a change or discontinuation of dietary needs</u> and to give to the school nurse. I give Broward County Public Schools FNS permission to speak with the state licensed healthcare professional to discuss dietary needs as ordered.			
X _____ PARENT/GUARDIAN SIGNATURE		DATE _____ CONTACT NUMBER OF PARENT/GUARDIAN _____	
Student First and Last Name		State licensed healthcare professional may assist parent/guardian in completing this section. Lactose Intolerance <input type="checkbox"/> No Yogurt due to Lactose Intolerance <input type="checkbox"/> No Cheese due to Lactose Intolerance <input type="checkbox"/> No Fluid Dairy Milk due to Lactose Intolerance Offer instead: <input type="checkbox"/> Lactose Free Cow's Milk <input type="checkbox"/> Water <input type="checkbox"/> Soy Milk Religious/Cultural Beliefs Food Restrictions <input type="checkbox"/> No Pork <input type="checkbox"/> Other: (Please Print) _____	
Student Date of Birth			
Name of School/Center			
Name of Parent/Guardian			
PART 2: ALLERGIES - COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL			
Section A: Student with Medical Disability/Life-Threatening Does the student have a disability which restricts the student's diet? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If Yes , describe or state the student's disability or diagnosis . Explain why it restricts the student's diet and list major life activities affected by the disability: _____ _____ _____ Food Allergy: Student has food allergies that ARE life threatening/anaphylactic: <input type="checkbox"/> Yes, continue with this section. <input type="checkbox"/> No, refer to section B. Milk/Dairy Allergy: Check ALL that apply. <input type="checkbox"/> No Fluid Dairy Milk <input type="checkbox"/> No Yogurt <input type="checkbox"/> No Cheese <input type="checkbox"/> No menu items with milk as an ingredient -- Substitute with <input type="checkbox"/> Soy Milk <input type="checkbox"/> Water Egg Allergy: Check ALL that apply. <input type="checkbox"/> No Whole Eggs (such as scrambled or boiled) <input type="checkbox"/> No menu items with egg as an ingredient <input type="checkbox"/> Soy Allergy (soy oil is allowed) Additional Food Allergies: (Please print) _____ _____		Section B: Student with NO Medical Disability/Non-Life-Threatening Student has allergies/intolerances that are NOT life-threatening/anaphylactic: Milk/Dairy Allergy: Check ALL that apply. <input type="checkbox"/> No Fluid Dairy Milk <input type="checkbox"/> No Yogurt <input type="checkbox"/> No Cheese <input type="checkbox"/> No menu items with milk as an ingredient -- Substitute with <input type="checkbox"/> Soy Milk <input type="checkbox"/> Water Egg Allergy: Check ALL that apply. <input type="checkbox"/> No Whole Eggs (such as scrambled or boiled) <input type="checkbox"/> No menu items with egg as an ingredient <input type="checkbox"/> Soy Allergy (soy oil is allowed) Additional Food Allergies: (Please print) _____ _____	
Indicate Food Texture for Above Student: <input type="checkbox"/> Regular <input type="checkbox"/> Pureed			
PART 3: SIGNATURE - COMPLETED BY A LICENSED MEDICAL PROFESSIONAL			
Printed Name of State Licensed Medical Professional		Title: <input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner (ARNP)	
Signature of State Licensed Medical Professional		Date Signed	
Medical Office Address		Medical Office Phone Number	



MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

The parent or guardian must complete Part 1. A *state licensed healthcare professional* who is authorized to write medical prescriptions under state law must complete *Parts 2 and 3*. In Florida, this includes a Physician, Physician's Assistant, or Nurse Practitioner (ARNP).

PART 1: GENERAL INFORMATION - COMPLETED BY THE PARENT/GUARDIAN

1. **Parent/Guardian Signature:** Read responsibility statement. Then, sign, date, and print phone number of the parent/guardian requesting the student/participant's special meal and/or accommodation.
2. **Student First and Last Name:** Print the name of the student that is asking a special meal and/or accommodation.
3. **Date of Birth:** Print the date the student was born.
4. **Name of School/Center:** Print the name of the location where the student will eat.
5. **Name of Parent or Guardian:** Print the name of the person who signed the responsibility statement.
6. **Lactose Intolerance:** Check all lactose containing foods that the student cannot have. Be sure to also check a drink that the student can have.
7. **Religious/Cultural Beliefs Food Restrictions:** Check all that apply. Include any additional foods the student cannot have due to religious or cultural beliefs.

PART 2: ALLERGIES - COMPLETED BY A STATE LICENSED HEALTHCARE PROFESSIONAL

Section A: Complete this section if Student has a Medical Disability that IS Life Threatening

8. **Does the student have a disability:** Check Yes or No.
 - a. "Student with a disability" is defined as any student who has a *physical or mental impairment* that substantially limits one or more *major life activities*, has a record of such impairment, or is regarded as having such an *impairment*.
 - b. "A physical or mental impairment is" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.
 - c. "Major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.
 - d. "Has a record of such an impairment" is defined as having a history of or has been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.
9. **Disability/Diagnosis:** Describe or state the student's disability or diagnosis and explain why it restricts the student's diet and list major life activities affected by the disability.
10. **Food Allergy:** Check Yes or No to indicate if student has a life-threatening food allergy. If yes, continue with Section A. If no, go to Section B.
11. **Milk/Dairy Allergy:** Check all foods that the student cannot have. Check a drink that the student/participant can have.
12. **Egg Allergy:** Check all foods that the student cannot have.
13. **Soy Allergy:** Check if applicable.
14. **Additional Food Allergies:** Print additional life-threatening food allergen(s) that the student is allergic to (e.g. Peanut, Tree Nut, Wheat, Fish, Shellfish, Sesame).
15. **Indicate Texture:** If the student or participant does not need any modification, check "Regular"

Section B: Complete this Section if Student does NOT have a Medical Disability/Non-Life-Threatening Food Allergy/Intolerance.

16. **Milk/Dairy Allergy:** Check all foods that the student cannot have. Check a drink that the student can have.
17. **Egg Allergy:** Check all foods that the student cannot have.
18. **Soy Allergy:** Check if applicable.
19. **Additional Food Allergies:** Print additional non-life-threatening food allergen(s) that the student is allergic/intolerant to (e.g. Peanut, Tree Nut, Wheat, Fish, Shellfish, Sesame).

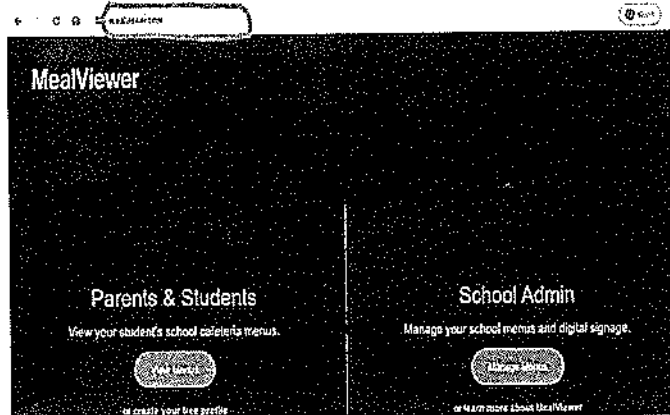
PART 3:

20. **Printed Name State licensed medical professional's name:** Print the name of the state licensed medical professional who oversees the care of the student.
21. **Title:** Check the box that describes the licensed medical professional's credentials.
22. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
23. **Date signed:** The date state licensed healthcare professional signed form.
24. **Medical Office Name:** Print the name of the office where the student receives care from the state licensed medical professional.
25. **Medical Office Address:** Address of state licensed medical professional's office / place of work.
26. **Medical Office Phone Number:** The phone number of the state licensed healthcare professional.

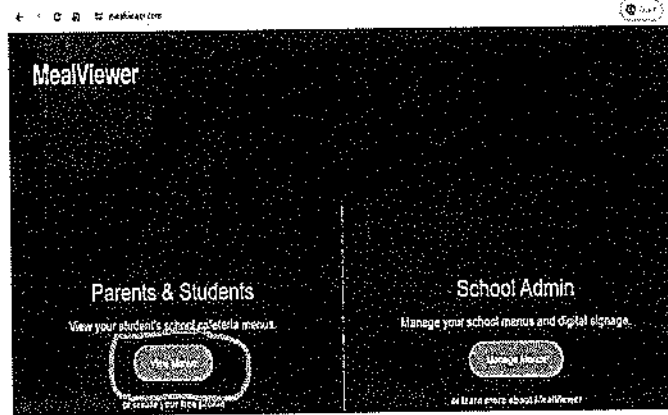
Meal Viewer Quick Guide

1. Search

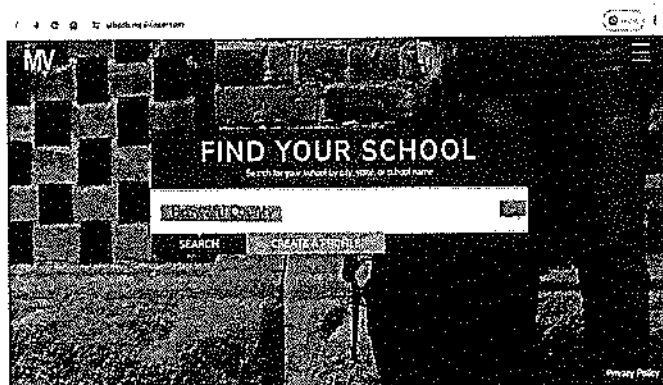
www.schools.mealviewer.com



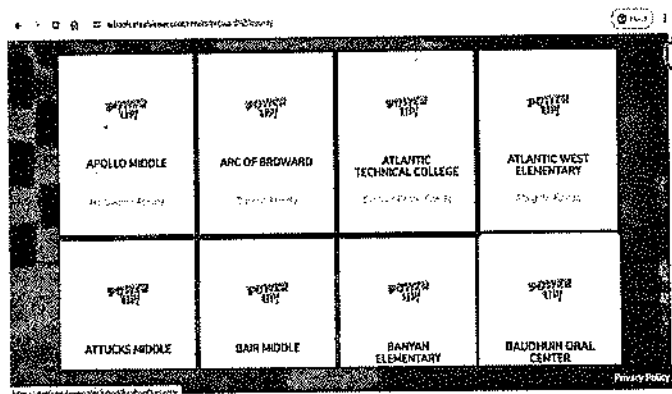
2. Select "View Menus"



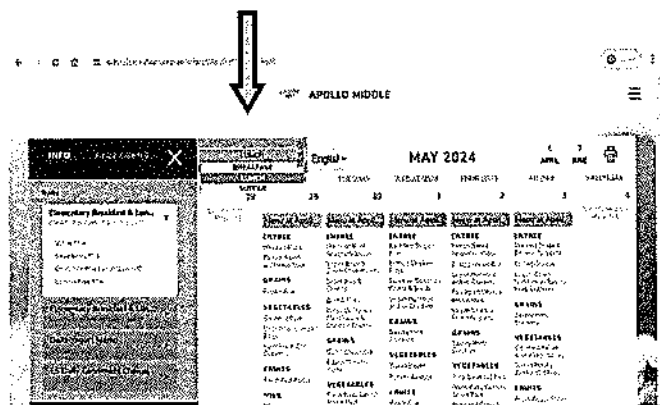
3. Search "Broward County"



4. Search for your School



5. Select Appropriate Dropdown (Breakfast or Lunch)



6. Hover over food item to view carb count and additional nutritional info

