Broward County Public Schools | Food and Nutrition Services Department

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 **any time there is a change or discontinuation of dietary needs** 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.**
Student Date of Birth	**Lactose Intolerance** ☐No Yogurt due to Lactose Intolerance ☐No Cheese due to Lactose Intolerance ☐No Fluid Dairy Milk due to Lactose Intolerance Offer instead: ☐Lactose Free Cow's Milk ☐Water ☐Soy Milk
Name of School/Center	
Name of Parent/Guardian	**Religious/Cultural Beliefs Food Restrictions** ☐No Pork ☐Other: (Please Print)_____

PART 2: ALLERGIES - COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL

Section A: Student with Medical Disability/Life-Threatening	**Section B: Student with NO Medical Disability/Non-Life-Threatening**
Does the student have a disability which restricts the student's diet? ☐Yes* ☐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: _____ _____ _____	**Student has allergies/intolerances that are NOT life-threatening/anaphylactic:** **Milk/Dairy Allergy:** Check **ALL** that apply. ☐No Fluid Dairy Milk ☐No Yogurt ☐No Cheese ☐No menu items with milk as an ingredient - - Substitute with ☐Soy Milk ☐Water **Egg Allergy:** Check **ALL** that apply. ☐No Whole Eggs (such as scrambled or boiled) ☐No menu items with egg as an ingredient ☐**Soy Allergy** (soy oil is allowed) Additional Food Allergies: (Please print) _____ _____
Food Allergy: Student has food allergies that **ARE** life threatening/anaphylactic: ☐Yes, continue with this section. ☐No, refer to section B.	
Milk/Dairy Allergy: Check **ALL** that apply. ☐No Fluid Dairy Milk ☐No Yogurt ☐No Cheese ☐No menu items with milk as an ingredient - - Substitute with ☐Soy Milk ☐Water	
Egg Allergy: Check **ALL** that apply. ☐No Whole Eggs (such as scrambled or boiled) ☐No menu items with egg as an ingredient	
☐**Soy Allergy** (soy oil is allowed)	
Additional Food Allergies: (Please print) _____	

Indicate Food Texture for Above Student: ☐ Regular ☐ Pureed

PART 3: SIGNATURE – COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

Printed Name of State Licensed Medical Professional	Title: ☐Physician	☐Physician Assistant	☐Nurse Practitioner (ARNP)
Signature of State Licensed Medical Professional	Date Signed VALID FOR ONE YEAR FROM THIS DATE		
Medical Office Address	Medical Office Phone Number		

Required annually. Valid for 1 year. This institution is an equal opportunity provider. Questions? Call 754-321-0215.

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.