# 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, After-school Snack Program, Summer Food Service Program)

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

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Birth Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Attended by Student:</td>
<td>Grade:</td>
</tr>
<tr>
<td>Parent/Guardian Name:</td>
<td></td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Parent/Guardian Signature:</td>
<td></td>
</tr>
</tbody>
</table>

## 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 Jocelyne Canestrelli @ jocelyne.canestrelli@asu.edu

For questions, contact Jocelyne Canestrelli  602-496-3126

This institution is an equal opportunity provider.