SOUTHSIDE COMMUNITY SCHOOL
MEDICAL STATEMENT FOR STUDENTS
WITH SPECIAL DIETARY ACCOMMODATIONS

U.S. Department of Agriculture (USDA) Child Nutrition Programs

Child's Name: ____ Birth Date: _______________

Grade: __________ Student ID#: ____________________________

Parent/Guardian Name: ____

Work Phone: ____________________________ Home Phone: __________________ Email: ___________________________

Parent/Guardian Signature: ____

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.

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

B. 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:___________

This institution is an equal opportunity provider.