SAHUARITA UNIFIED SCHOOL DISTRICT #30

SAHUARITA HIGH SCHOOL
SAHUARITA MIDDLE SCHOOL
SAHUARITA PRIMARY SCHOOL
ANZA TRAIL SCHOOL
WALDEN GROVE HIGH SCHOOL
SAHUARITA INTERMEDIATE SCHOOL
SOPORI ELEMENTARY SCHOOL
COPPER VIEW ELEMENTARY SCHOOL
EARLY CHILDHOOD CENTER

SCHOOL HEALTH SERVICES

Parent Food Restriction or Special Needs Diet Information Letter

To the parent of _____ Date: _____

While reviewing the *Student Health History Form* you completed for your child, it was noted you indicate he/she may have a medical condition requiring a special needs diet (list special dietary need): _____

In order to provide better health care services for your child in school, we need to know if this is currently an issue, and if your child requires special medical diet, food substitution, and/or observation for this condition at school.

Please complete the section below and return to me at school, with appropriate documentation as requested. If you have any questions or concerns please feel free to contact me at any time. All medical information is confidential and will be shared only with teaching staff working directly with your child.

Thank you.

_____
School Health Staff

Please check the box next to the most appropriate statement for your child, sign the bottom of this page and return to the school health office.

- ☐ This is not a health concern.
- ☐ My child does have the following condition _____ which requires a special dietary needs (Describe)

_____
_____

PLEASE PROVIDE THE FOLLOWING DOCUMENTS **ANNUALLY** TO THE SCHOOL HEALTH OFFICE:

- ☑ **Medical Statement for Student with Food Allergy, Food Restriction or Special Needs Diet** form signed by a Licensed HealthCare Provider (provide once and update as needed). If this form is NOT submitted to the School Health Office, then the cafeteria can NOT make accommodations for your child.
- ☑ **Please see school health staff if your child requires medications to be given at school.**

_____ _____ _____
Name of Parent and/or Guardian Signature Date

Medical Statement for Student with Food Allergy, Food Restriction or Special Needs Diet
(Update Anytime Food Allergy, Food Restriction, or Special Needs Diet Changes)

PART 1: To be completed by a Parent or Guardian:

Name of Student: _____ Date of Birth _____ Gender: M F

School: _____Grade: _____ Teacher _____

Name of parents/guardians: _____

Home Phone: _____Work Phone: _____Cell: _____

PART 2: To be completed by a Licensed Primary Care Provider/Physician:

Patient Diagnosis:_____

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification:_____
Food Allergies or Intolerances:_____

Are any of these Food Allergies potentially Life Threatening for this student? Yes No
(If Yes, Complete the "Food Allergy Action Plan" and consider prescribing multiple EpiPens (for home, school health office, and to be stored in classroom or carried by the student as age appropriate) or other necessary medications as needed.
Which Food(s) may be life threatening: _____

Food Substitutions: _____
Indicate which dietary modification the patient needs and specify what changes need to be made:

- ☐ Texture Modification:
  - ☐ Pureed
  - ☐ Ground
  - ☐ Chopped
  - ☐ Other _____
  - Specify Foods _____
- ☐ Tube Feeding: Formula Name: _____
  Administration Instructions: _____
  Oral Feeding: Yes No If Yes, Specify Foods: _____
- ☐ Nutrient Modification
  - ☐ Increase calories Description_____
  - ☐ Supplement Name _____
  - ☐ Decrease calories Description _____
  - ☐ Nutrient Restriction Description _____
- ☐ Special Mealtime Equipment: _____
- ☐ Other: _____

Dietician Name and Phone Number (if applicable): _____

Physician's Name _____ **Phone Number:** _____

Physician's Signature_____ **Date:** _____
(Required)