Request for Accommodations for Special Dietary Needs

This form is to be completed by a licensed physician (or other medical authority) or parent/guardian for students who have been diagnosed with a life threatening food allergy or a disability and require a special diet or food accommodation. Please note, an individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as well as the USDA's nondiscrimination regulation, as a person who has physical or mental impairment that substantially limits one or more major life activities and that all reasonable requests for food and beverage substitutions will be made so the student can eat.

***** In order to best and safely accommodate students, this form should be filled out in its ENTIRETY and be turned into the school nurse before or on the first day of school. Forms that are not filled out entirely and accurately can potentially cause unnecessary dietary restriction or inaccurate accommodation.*****

PART I - Parent/Legal Guardian to complete this section: **Student Grade:_____** **Sex:** M F

Student Last Name_____ Student First Name_____

Parent/Legal Guardian Name (s)_____ Phone # _____

Parent/Legal Guardian Name (s)_____ Phone #_____

Parent/Legal Guardian Email Address:_____

Which of the above is the best way to contact parent/guardian with questions? Phone Email

PART II – Parent/Legal Guardian OR Licensed Physician to complete this section:

Does the student have an allergy or intolerance that requires them to have a milk substitute?

☐ Yes ☐ No

Explain why the student needs a milk substitute.

_____

_____

Appropriate substitutions:

_____

_____

Are yogurt and cheese acceptable? ☐ Yes ☐ No

Is milk as an ingredient acceptable? ☐ Yes ☐ No

Physician Signature:	Date Signed:_____
Printed Name of Physician:	Phone #_____

Please see reverse side in order to complete form.

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PARENTAL CONSENT: By signing this form, I consent to the sharing of this information with appropriate district staff (this includes but is not limited to administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches and substitute employees). I also agree TO THE FOLLOWING: Notify the school if the food allergy or epinephrine prescription is changed or discontinued; Grant permission for the school nurse to confer with the doctor regarding health and treatment issues as they pertain to the above medications and or diagnosis as related to his/her educational and behavior management needs; Provide safe transportation of the medication to and from school to a school official and to provide a back-up dose of Epinephrine if needed. **By signing this form, I also acknowledge that falsifying or inaccurately reporting any of the information on this form can result in delayed or inaccurate accommodation, unnecessary restriction of diet, and potential danger to my child. The North White School Corporation shall not be held liable for any harm caused by inaccurate reporting by legal guardian or Licensed Physician on this form.**

Signature of Parent/Guardian: **Date:**

School Use Only:

- ☐ **Form Received on _____.**
- ☐ **Form incomplete. Parent contacted on _____.**
- ☐ **Accommodations will begin on _____.**
- ☐ **Separate Doctors note on file.**

Signed:_____

Printed:_____

Please see reverse side in order to complete form.