



Diet Order Modification Letter

Dear Parent/Guardian,

The Arizona Department of Education (ADE) issued guidelines regarding children with special dietary needs. These guidelines require the district to make changes to our recordkeeping for diet modifications. Attached are new forms which will give us the necessary information and authorization to make diet modifications for meals at school.

Confidential Diet Order, Request for Diet Modification for Meals at School

This form **must** be completed for every student with a special dietary need. This includes food allergies resulting in severe or life threatening reactions and/or disabilities, which require special diet modifications. The form **must** be completed and signed by a licensed Physician or Recognized Medical Authority. A **recognized** medical authority includes Naturopathic or Osteopathic Physician, Licensed Physician, Physician Assistant, Registered Dietitian, or Nurse Practitioner.

The district serves thousands of meals per day. While a reasonable attempt will be made to accommodate the modifications requested, meals from home are highly recommended and provide the safest alternative.

Please return this form to your school front office or mail them to the address listed below.

Sincerely,
Nutrition Services

Dysart Unified School District
p: 623-876-7075 **f:** 623-876-7088
a: 13825 W Desert Cove Rd., Surprise, AZ 85379
w: www.dysart.org **e:** nutrition@dysart.org
s: Visit us on Social Media @DysartUSD

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, Afterschool Snack Program, Summer Food Service Program)

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

Child's Name: _____ Birth Date: _____

School Attended by Student: _____ Grade: _____ Student ID#: _____

Parent/Guardian Name: _____

Work Phone: _____ Home Phone: _____ Email: _____

Parent/Guardian Signature: _____

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 your school's Health Office.

For questions, contact Nutrition Department by calling 623-876-7075 or email allyson.geary@dysart.org