WCPS Department of Food & Nutrition Services

Medical Form for Students with Special Dietary Needs

The Special Dietary Needs form is exclusively for use in the WCPS National School Breakfast, Lunch, Dinner and Snack programs administered by the Department of Food and Nutrition.

Should your child require special medical consideration for a condition unrelated to dietary needs, please contact your child's school nurse.

This Food and Nutrition form should be completed and turned into your child's school health room if:

1) Your child is new to WCPS and has a special dietary need

OR

2) Your child develops a special dietary need that has not been requested/reported in the past

OR

3) Your child's special dietary needs change

Instructions to complete the
Medical Form for Students with Special Dietary Needs

- Forms do not need to be submitted each year - once a form has been submitted, the information will follow a student from year to year.
- Another form should be submitted only if there is a change to a student's special dietary need.

- **Parents/Guardians** – Complete Part I **ONLY**

- **Physicians** – Complete Part II only if the student requires a special diet that is classified as a disability or medically identifies a specific food allergy. *(Any information completed in Section II without a physician's signature and phone number will be disregarded.)*

  When food allergies exist, or when water or juice is required in place of fluid milk due to a disability, **Part II** of this form must be completed by a physician indicating:
  - The student has an identified disability that requires him/her to have a special diet, and the specific foods that are to be omitted and/or included as part of a prescribed special diet
  - If a disability exists, the major life activities affected by the disability
  - If a food allergy exists, if it is life threatening
  - The specific food to which an allergy exists and appropriate substitutions

- The completed form should be turned in to your child's school health room.

PLEASE NOTE REGARDING MILK

WCPS will provide soy milk or lactaid in place of regular milk at a parents/guardians request *(see Part I below)*. A Doctors note is **not** required for a soy/lactaid substitution due to an intolerance or allergy.

In order for a student to receive water or juice in place of fluid milk in the National School Breakfast/Lunch programs, a physician must diagnose a student's diet restriction as a **disability** and provide all required information under Part II of this form.

Under Federal School Breakfast/Lunch regulations, an intolerance or allergy is not a disability.

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Revised 7/16

USDA regulations require a signed medical statement from a recognized medical authority in order for the cafeteria to make substitutions for students with a life threatening food allergy, disability, or medical condition that requires a special menu or substitution.

Part I – To be completed by a Parent/Guardian if a special dietary need exists

Student's Name:	Grade:	School:	Birth Date:

Due to specific special dietary needs, my child will not eat school provided meals: ☐	☐ Lactose Intolerance: Instead of milk please provide my child with: ☐ soy milk ☐ lactaid
☐ Please provide my child with a vegetarian menu ☐ Please provide my child with a vegan menu	☐ My child **had** a food allergy or intolerance but no longer does. Please remove all restrictions.
☐ For religious reasons please do not allow my child to have the following foods:	
☐ My child has a food intolerance to_____ . Please assist my child to ensure they make appropriate food selections that omit the following:	

I give Food and Nutrition Services and or the school nurse permission to speak with the below named physician or Authorized Medical Authority to discuss the dietary needs described in Part II: ☐ Yes ☐ No

_____ _____

Parent/Guardian Name Printed **Parent / Guardian Signature / Date**

----------***PARENTS/GUARDIANS – DO NOT WRITE BELOW*** ----------

Part II – To be completed only by a physician or health care provider

Does the child have an identified disability that requires him/her to have a special diet? ☐ Yes ☐ No
If yes, please describe the major life activities affected by the disability:_____

Does the child have a life threatening food allergy? ☐ Yes ☐ No

Food Allergies: Check appropriate box(es): ☐ ingestion ☐ contact ☐ inhalation

☐ **milk**	☐**wheat**	☐ **soy**	☐ **peanuts**	☐ **tree nuts**
☐ **fish**	☐ **shellfish**	☐ **whole eggs**	☐ **egg as an ingredient**	☐ **gluten**
☐ **other (please be specific):**				

Physician Office Phone # :	Physician Office Fax # :

_____ _____

Physician Name Printed **Physician Signature / Date**

Return completed form to your child's School Health Room