



Medical Statement for Students Requiring Special Meals or Accommodations

Instrucciones: Padre o Tutor debe completar la forma en la sección 1. Sección 2 (área sombreada) debe ser completada por un MD, DO, RNP, o PA. Devuelva la forma completada al Departamento de Alimentos y Servicios de Nutrición. **Esta declaración debe actualizarse cuando hay un cambio o interrupción de un plan de sustitución de dieta.**

Sección 1 ** Debe ser Completado Por un Padre/Tutor**			
Nombre de Estudiante		Fecha de nacimiento	
Nombre de Escuela	Grado	Salon	
Mi hijo (a) ya no requiere de una dieta modificada <input type="checkbox"/> _____ <div style="display: flex; justify-content: space-between;"> Firma de Padre/Tutor Fecha </div>			
Esta petición es dada a razones religiosas o preferencias personales Sí <input type="checkbox"/> No <input type="checkbox"/>			
Doy permiso al personal de la escuela que siga el plan de nutrición que se describe a continuación. Doy mi permiso para el personal de School City of Hammond para que contacten al doctor nombrado abajo con cualquier pregunta relacionada a las necesidades de nutrición de mi hijo(a) y compartir la información con el personal apropiado de la escuela.			
Firma de Padre/Tutor		Fecha	
Numero de teléfono de día _____		Número de teléfono de casa _____	
Section 2 ** To Be Completed By MD, DO, RN Practitioner, or Physician Assistant**			
Is this child disabled?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes , describe the major life activities affected by the disability and requiring special nutritional or feeding needs.			
Describe the child's condition that requires a diet modification:			
Indicate foods to avoid and whether the condition is an allergy or food intolerance. If an allergy is indicated we will not serve the student any menu item containing the allergen (e.g., milk allergies will also eliminate cheese, ice cream, or any item containing these foods such as pizza, mashed potatoes, baked goods containing milk.).			
Milk intolerance <input type="checkbox"/> No fluid milk only (may have yogurt, cheese, and other dairy)			
Milk intolerance <input type="checkbox"/> No milk products (no fluid milk, yogurt, cheese, and dairy products)			
Milk intolerance <input type="checkbox"/> No milk products or products containing milk (e.g., mashed potatoes, baked goods that contain milk)			
Allergy <input type="checkbox"/> Food: _____ Requires Epi-Pen? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Allergy <input type="checkbox"/> Food _____ Requires Epi-Pen? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Allergy <input type="checkbox"/> Food: _____ Requires Epi-Pen? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Other diet modifications:			

List foods/beverages to be omitted:			
List foods/beverages to be substituted:			



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Student:	School:
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground: Pureed:	
Indicate any other comments:	
MD, DO, RNP, or PA Signature (Required for all disabilities)	Date:
Physician Printed Name and Office Phone Number	
Medical Authority's Signature (Required for all other medically required modifications)	Date:
Medical Authority's Printed Name and Phone Number	

Send completed and signed Diet Plan by mail, fax, or email to:

Department of Food and Nutrition Services
41 Williams Street
Hammond, IN 46320

Email: crclarahan@hammond.k12.in.us
Fax: 219-554-4502

If you have questions please contact:
Christine Clarahan MS, SNS, RDN
Director of Food & Nutrition
Registered Dietitian Nutritionist
219-933-2400

School City of Hammond menus are posted on www.SCHLunch.com

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