Nixa Schools Health Services

Medical Statement for Student Requiring Special Meals

Student Name______________________________________DOB______________Grade________Date_______________

Diagnosis____

Identify and describe disability or medical condition, including allergies, that requires the student to have a special diet. Describe the major life activities affected by the student's disability.

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Diet Prescription (Check all that apply)

Modified Texture and/or liquids   Reduced Calorie   Increased Calorie

Food Allergy (describe severity)____

Other ____

Food Omitted and Substitutions

Use space to list specific foods to be omitted and foods that may be substituted. You may attach an additional sheet if necessary.

Omitted Foods	**Substitutions (Soy Milk and Juice are available)**

Indicate food texture:

Regular   Chopped   Ground   Pureed

Indicate thickness of liquids:

Regular   Nectar   Honey   Pudding

Student Name____DOB_______________________

Lunchroom Seating Requirements

For your child's safety, please mark the lunchroom seating needs your child requires to prevent an allergic reaction:

My child **does not require any special seating** in the lunchroom to prevent an allergic reaction. I understand other students at the regular lunchroom tables may have a food my child could react to in their lunchbox or on their lunch tray.

My child **requires seating at a separate table in the lunchroom**. I understand this table is away from the other student lunch tables to prevent cross-contamination. I also understand a friend may eat at this table, IF their lunch does not contain a food that could initiate an allergic reaction. I also understand by sitting at a separate table, other students may learn my child has a food allergy.

My child **requires seating outside the lunchroom** to prevent an allergic reaction, because my child can react from just being near the previously listed food/foods.

I certify that the above named student has a disability or chronic medical condition that requires special school meals and/or requirements as described.

Physician Signature____Date_________________

Physician Name (Printed)____Phone_________________

Parent/Guardian Signature____Date_________________

Parent/Guardian Name (printed)____Phone________________