FNS REQUEST
for Special Nutritional Needs
Annual Medical Statement for Students

School Year: _____ *(Año escolar)*

Parent/Guardian: Complete Items 1 – 9 *(Padre/madre/tutor: complete la información en los espacios 1 al 9)*		
1) Student's Last Name *(Apellido)*	**2) Student's First Name** *(Nombre del estudiante)*	**3) Date of Birth** *(Fecha de nacimiento)*

4) School(escuela) _____**Grade** (grado)**:**_____ **Student ID#** *(Numero de estudiante):* _____

5) Circle Meals Eaten at School
(Circule los alimentos que su niño(a) consumirá en la escuela)

Breakfast *(Desayuno)*	**Lunch** *(Almuerzo)*	**Snack** *(Bocadillo)*	**None** *(Nada)*

6) Parent/Guardian Name & Phone Number
(Nombre & Número de teléfono del padre/madre/tutor)

*Name (Nombre):*_____
Phone Number (*Teléfono):* ( )_____-_____

7) Allowable Parent Reports:

☐ **Lactose Intolerance**(*intolerancia a lactosa*) **(Lactaid Milk needed)** (*necesita leche Lactaid*)
Circle if can eat (*circule si puede comer*) **Cheese** (*queso*) **Yogurt** (*yogur*)

☐ **Cultural/Religious Preference** (*preferencias culturales/religiosas*) _____

☐ **Other (Must be diagnosed by physician using back of this form)**
(*Otro - debe ser diagnosticado por un médico en la parte de atrás de esta forma)*

8) I consent to the exchange of information between the physician and school, as needed.
(Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)

Parent/Guardian Signature _____ **Date:** _____
(Firma del padre/madre/tutor) *(Fecha)*

Print Name of Parent/Guardian _____
(Escriba en letra de molde el nombre del padre/madre/tutor)

9) Parent/Guardian: It is REQUIRED that this completed form is returned to the cafeteria manager. All further changes to the child's diet must be made by a physician on a new form with the exception of lactose intolerance or cultural preference. The manager will add the alert to the cashier system & return the form to the District FNS Office for consideration.
(Padre/madre/tutor: Se REQUIERE que se devuelva la forma debidamente completada al gerente de la cafetería. Cualquier cambio en la dieta del estudiante debe ser hecho por un médico en una nueva forma, a excepción de la intolerancia a lactosa o preferencias culturales. El gerente de la cafetería entraré un alerta en el sistema de cajeros y devolverá la forma a las oficinas de Alimentos y Nutrición del Distrito)

*Information regarding major allergens **and** nutrient/carbohydrate information are available for review at http://pasco.nutrislice.com (*Ver información sobre alergenos y nutrientes/carbohidratos en http://pasco.nutrislice.com)*

Cafeteria Manager: Complete Items 10 – 16 *(10 al 16 - Para ser completado por el gerente de la cafetería escolar)*	
10) School Name	**11) Student assigned in:** ☐ **PreK/EHS** ☐ **PreK VE** ☐ **Charter** ☐ **K-12**
12) School Nurse	**13) School Nurse's Email**
14) Cafeteria Manager (C.M.)	**15) C.M. Email Address**
16) Is there an IEP/504 in place at the school that includes dietary restrictions/accommodations? ☐ **Yes** ☐ **No**	

Cafeteria Managers: **Return completed (including back) form to:**
District School Board of Pasco County
Food and Nutrition Services
7227 Land O' Lakes Blvd.
Land O' Lakes, Florida 34639
Phone: (813) 794-2436 Fax: (813) 794-2118
Email: FNSDietRequest@pasco.k12.fl.us

Once received copies will be distributed to:
- **District Office**
- **Cafeteria Manager**
- **School Nurse**

COMPLETED BY THE PHYSICIAN ONLY

COMPLETED BY THE PHYSICIAN ONLY: Complete Items 17 – 25
(*17 al 25 - Esta sección para ser completada por el médico solamente*.)

17) Please check all that apply:

☐ **Milk** ☐ **Egg** ☐ **Wheat** ☐ **Soy** ☐ **Peanut** ☐ **Tree Nut** ☐ **Fish** ☐ **Shellfish**

☐ **Other** _____

18) Food Allergies: Indicate the severity of sensitivity to the food(s) the child is allergic to by checking a box below:

☐ Omit all sources of this food **OR** ☐ Omit major sources of this food (i.e.: egg in baked goods is ok)

19) Does the student have a disability, medical condition, or severe food allergy warranting a special diet?

A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

☐ **YES** If "YES", continue to complete the remainder of this form.

☐ **NO** **If "NO", SKIP TO #23. A SPECIAL DIET IS NOT WARRANTED.**

20) Disability/Medical Condition: State the disability as well as provide a brief description of the **major life activity** affected by the food related disability.

_____

_____

21) Food(s) to be Omitted and Suggested Substitutions:
(Juice is not an allowable substitution for milk per USDA federal regulations)

Food(s) to Omit	**Suggested Substitution(s)**

22) Texture Modification: If needed, circle **one** appropriate for the student: **CHOPPED** **GROUND** **PUREED**

23) Physician's Signature & Date	**24) Physician's Stamp**
25) Physician's Phone Number	

For Pasco County Schools District Office Use Only

☐ Approved ☐ Declined **DSBPC RD/DTR Signature** _____ **Date** _____