



FNS REQUEST
for Special Nutritional Needs
Annual Medical Statement for Students

DO NOT WRITE IN THIS AREA

9532049620

School Year: _____ (Año escolar)

PART A Parent / Guardian: Complete Items 1 - 16 (Padre/madre/tutor: complete la información en los espacios 1 al 16)

1) Student ID# (Numero de estudiante)	2) Student's Last Name (Apellido)	3) Student's First Name (Nombre del estudiante)	4) Date of Birth (Fecha de nacimiento)

5) School (Escuela)	6) Grade (Grado)	7) Student assigned in:
		☐ PreK/EHS ☐ PreK VE ☐ Charter ☐ K-12

Parent/Guardian Name & Contact Information (Nombre & Información del contacto)

8) Name (Nombre)	9) Phone Number (Teléfono)	10) Mailing Address, City, State, Zip (Dirección postal, ciudad, estado, código postal)

11) E-mail Address (We will use this to send acknowledgement and details of your child's menú plan. PRINT NEATLY)
Dirección electrónica (será usada para acuso de recibo y detalles sobre el menú de su niño. IMPRIMA)

12) Meals Eaten at School (Los alimentos que su niño(a) consumirá en la escuela) ☐ Breakfast (Desayuno) ☐ Snack (Meriendao) ☐ Lunch (Almuerzo) ☐ None (Nada)	13) Allowable Parent Request: (Solicitud de los padres) ☐ Lactose Intolerance (intolerancia a lactosa) (Lactaid Milk needed) (necesita leche Lactaid) Mark if student cannot eat (marque si no puede comer) ☐ Cheese (queso) ☐ Yogurt (yogur) ☐ Cultural/Religious Preference (preferencias culturales/religiosas) Mark if student cannot eat (marque si no puede comer) ☐ Pork (carne de cerdo) ☐ Beef (carne de res) ☐ Other (otro) _____ ☐ Other Condition (Must be diagnosed by physician using Part B) (Otro condición- debe ser diagnosticado por un médico en la parte B)
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14) Does the student have an identified disability (IEP or 504 Plan)?
¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)? ☐ Yes (Si) ☐ No

15) 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 (required for processing) (Firma del padre/madre/tutor - requerido para ser procesado)	Date (Fecha)
X	

16) 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 añadirá 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://schools.mealviewer.com/district/pascocounty>
(Ver información sobre alérgenos y nutrientes/carbohidratos en <http://schools.mealviewer.com/district/pascocounty>)

PART B COMPLETED BY THE PHYSICIAN ONLY: Complete Items 17 – 20 (17 al 20 - Esta sección para ser completada por el médico solamente.)

17) Student Diagnosis or Condition ☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy *** Students with life threatening food allergies must have an emergency action plan in place at school.**
☐ Other (Specify) _____

18) Please check all food(s) to omit from child's diet during the school only (not to be used as a medical history):

DAIRY ☐ Fluid Milk. Substitute with ☐ lactose-free milk ☐ soy milk ☐ water ☐ Cheese and recipes with cheese listed as an ingredient ☐ Ice Cream ☐ Yogurt ☐ Baked goods with any dairy listed as an ingredient EGG ☐ Whole eggs such as scrambled eggs or hard cooked eggs ☐ Baked goods with any egg listed as an ingredient WHEAT / GLUTEN ☐ Recipes with any wheat listed as an ingredient ☐ Recipes with any gluten containing grain listed as an ingredient FISH OR SHELLFISH ☐ Fish ☐ Shellfish	PEANUTS OR TREE NUTS ☐ Peanuts ☐ Tree Nuts SESAME ☐ Whole sesame such as sesame seeds ☐ Recipes with any sesame products listed as an ingredient SOY ☐ Soy Lecithin ☐ Soy Protein (concentrate, hydrolyzed, isolate) ☐ Recipes with any soy listed as an ingredient OTHER ☐ Other, specify if it is a cooked ingredient or when consumed fresh _____
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19) Does the student have a disability, medical condition, or severe food allergy warranting a special diet? ☐ Yes If "YES", specify disability below
A disability is defined as a physical or mental impairment which substantially limits one or more major life activities. ☐ No If "NO", A SPECIAL DIET IS NOT WARRANTED.

Disability (specify) _____ Describe major life activities affected _____

FOOD TEXTURE MODIFICATION If medically needed check ONE: ☐ Pureed ☐ Ground ☐ Chopped

20) LICENSED PHYSICIAN'S INFORMATION *Diet Order Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.*

Medical Authority Signature X Medical Authority Printed Name 	Date - 202	Medical Office Stamp (Required for processing)
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Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture

Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992.

Haga llegar su formulario lleno o carta al USDA por:

(1) correo: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue,
SW

Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; o

(3) correo electrónico: program.intake@usda.gov.

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