



Queen Creek Unified School District

(480) 987-5935 | www.qcUSD.org | 20217 East Chandler Heights Rd. Queen Creek, AZ

MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY ACCOMMODATIONS

Requesting Dietary Accommodations in the U.S. Department of Agriculture (USDA) Child Nutrition Programs (National School Lunch Program, School Breakfast Program, Afterschool Snack Program, Summer Food Service Program)

PART 1 TO BE COMPLETED BY PARENT/GUARDIAN. PLEASE PRINT.

Child's Name: _____ Birth Date: _____

School Attended by Student: _____ Grade: _____ Student ID#: _____

Please select one of the following statements:

- I will review the online menu and ingredients with my child and they will purchase the school-provided meals.
- My child will always eat breakfast at home and bring a lunch to school packed at home.
- I request the QCUSD to accommodate my child's dietary needs. (This form will require physician documentation)

Parent/Guardian Name: _____

Work Phone: _____ Home Phone: _____ Email: _____

Parent/Guardian Signature: _____

PART 2 TO BE COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL*

For purposes of Child Nutrition Programs, only a "Licensed Healthcare Professional" is permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs. The seven medical professionals listed are permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs administered in Arizona. (HNS# 11-2015). **Dentists, Homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians.*

A. Select foods/ingredients to be omitted from the diet.

- Peanuts
- Sesame
- Gluten (please circle one)
Celiac disease or Gluten intolerance
- Pork (please circle one)
Allergy or Religious/Personal preference
- Eggs
May the child eat eggs in baked goods? Yes No

Dairy Products (please circle one)

Lactose intolerant or Dairy allergy

If Lactose intolerant, please circle the food(s) that the child is allowed to eat:

Pizza Cheese Ice Cream Yogurt Milk

Gluten (please circle one) Celiac disease or Gluten intolerance

Pork (please circle one) Allergy or Religious/Personal preference

Tree nuts (please specify) _____

Fish/Shellfish (please specify) _____

Soy Products (please specify) _____

Fruit (please specify) _____

Other (please specify) _____

B. Provide a brief explanation of how exposure to food affects the child.

C. List foods/ingredients that can be substituted into the diet to accommodate the dietary restriction.

This medical statement is: _____ Permanent *(This medical statement will remain in effect during the time the student is enrolled. A new medical statement will be required to change any aspect of information provided in this medical statement.)*

This medical statement is: _____ Temporary *(This medical statement will remain in effect for the current school year. A new medical statement will be required annually.)*

Licensed Healthcare Professional Name: _____ Office Phone Number: _____

Licensed Healthcare Professional Signature: _____ Date: _____

Return the completed form to Bailey Hanson via email bhanson@gcusd.org or drop off with school nurse. For questions, contact please call or email Bailey Hanson, Nutritionist, at (480) 987-7485.

This institution is an equal opportunity provider.