

CHILD NUTRITION DEPARTMENT STAFFORD MSD

PHYSICIAN STATEMENT

**Form does NOT need to be renewed every year. Fill out new form only if dietary needs have changed.
Send completed form to student's school nurse.**

A. THIS SECTION TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Date _____ Student Name _____ ID Number _____ Date of Birth ___/___/___

School _____ Parent/Guardian _____ Phone Number _____

B. THIS SECTION TO BE COMPLETED BY STATE LICENSED HEALTHCARE PROFESSIONAL AUTHORIZED TO WRITE PRESCRIPTIONS

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, a person with a disability is any person who has a physical or mental impairment that substantially limits one or more life activity, including food anaphylaxis.

1. Student's Medical Condition/Disability (REQUIRED): _____

2. Explain why the disability restricts the student's diet (REQUIRED): _____

3. Major life activity affected by the disability (eating, walking, seeing, hearing, breathing, learning/reading, speaking, performing manual tasks, caring for one's self, major bodily function) (REQUIRED): _____

4. List all food allergies: _____

5. Substitutions to serve in place of omitted food(s) (REQUIRED): _____

6. Texture Modification (*if applicable*):

Pureed Soft Chopped, specify size: _____ (ex. 1/4" bite-sized pieces)

Other: _____

C. PHYSICIAN INFORMATIONS

Name of State Licensed Health Care Provider: _____

State Licensed Health Care Provider's Signature: _____

Clinic Name: _____ Phone Number: _____ Fax: _____

Changes to dietary treatment must be in writing by State licensed healthcare professional. Discontinuation of an accommodation for diet modification can be submitted in writing by State licensed healthcare professional or child's parent/guardian. Phone number must be included on parent's statement. Send statement to the student's school nurse.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-DASCRC%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

mail:

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

fax:

(833) 256-1665 or (202) 690-7442; or

email:

program.intake@usda.gov

This institution is an equal opportunity provider.

Revised 8/31/2022