THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
FOOD AND NUTRITION SERVICES
101 OLD VENICE ROAD, OSPREY, FL 34229
PHONE (941) 486-2199 FAX (941) 486-2021

MENU MODIFICATION MEDICAL STATEMENT
MEDICAL STATEMENT FOR STUDENTS FOR SCHOOL YEAR 2018-2019

Instructions: The parent/guardian is required to return this form to the Food and Nutrition Services Central Office at the above contact information. All changes to the child's diet must be made by a physician on a new form with the exception of lactose intolerance. By signing this form, you give Food and Nutrition Services the right to contact your child's physician for clarification regarding dietary restrictions. Information regarding major allergens and nutrient/carbohydrate information is available for review at http://sarasotacountyschools.nutrislice.com.

Student Name ______________________________ DOB ____________

School ______________________________ Grade ________

Check meals eaten at school ☐ Breakfast ☐ Lunch ☐ Snack ☐ Supper ☐ None

______________________________ ______________________________
Parent/Guardian Name (Print) Phone Number

Parent Request: ☐ Lactose Intolerance/Lactaid Milk Needed
If lactose intolerant, check if child can eat ☐ Cheese ☐ Yogurt

☐ Other (**Must** be diagnosed by physician by completing the section below)

Parent/Guardian Signature ______________________________ Date ____________

PHYSICIAN ONLY: COMPLETE ALL ITEMS BELOW

Check all food(s) to omit from child's diet at school only (not to be used as medical history):

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

☐ Other ______________________________

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/milk in baked goods is ok)

Comments ______________________________

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Distribution: Original – District Office Copy – Cafeteria Manager Copy – School Nurse

MENU MODIFICATION MEDICAL STATEMENT
ANNUAL MEDICAL STATEMENT FOR STUDENTS FOR THE 2018-2019 SCHOOL YEAR

Student Name ____ DOB ____________________

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", **A SPECIAL DIET IS NOT WARRANTED.**

Disability/Medical Condition: State the disability and a brief description of the **major life activity** affected by the food related disability.

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Food(s) to be omitted and suggested substitutions:
(Juice is not an allowable substitution for milk per USDA federal regulations; suggestions will be considered by Food and Nutrition Services, but cannot be guaranteed)

Food(s) to Omit	Suggested Substitutions(s)
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Texture Modification: Check **one** appropriate for the student: ☐ Chopped ☐ Ground ☐ Pureed ☐ Not needed

______________________________________ Physician Stamp (Below)
Physician Name (Print)

Physician Phone ______________________________

______________________________________ ____________________
Physician Signature Date

FOR SARASOTA COUNTY SCHOOLS DISTRICT USE ONLY

☐ Approved ☐ Declined

____________________ ____________________ ____________________
Nutrition Educator Name (Print) Nutrition Educator Signature Date