

CONFIDENTIAL DIET ORDER

Request for Diet Modification for Meals at School

FOR LIFE-THREATENING ALLERGIES, MEALS FROM HOME PROVIDE THE SAFEST ALTERNATIVE. ***

Part I (To be completed by Parent/Guardian)

Student's Name: (Last) _____ (First) _____ (MI) _____

Date of Birth ____/____/____ Age _____ Grade _____ School _____

Parent/Guardian's Name and Daytime Phone Number(s) _____ () _____ - _____

Part II (to be completed by Parent/Guardian)

Does the child have a life-threatening food allergy? Yes No *(If yes, Licensed Physician only must complete Part III.)*

Does the child have a disability? Yes No *(If yes, Licensed Physician only must complete Part III.)*

Does the child have a special dietary need? Yes No *(If yes, a Recognized Medical Authority must complete Part III.)*

Part III (To be completed by a Licensed Physician or Recognized Medical Authority)

Life Threatening Allergy: _____

Student's Disability and Nutrition Impact: _____

Student's Special Dietary Need: _____

Indicate which dietary modification the student needs and specify what changes need to be made:

Foods to be substituted/omitted: _____

Texture Modification: _____ Special Mealtime Equipment: _____

Other: _____

I am a (please check one of the following): Licensed Physician OR Medical Authority

Name _____ Phone () _____ - _____

Address _____

Signature (Required) _____ **Date** _____

***Any change of treatment must be requested in writing by the physician or recognized medical authority.**

Parent/Guardian Consent:

By Signing below, I authorize the Nutrition Department to access the information on this form. I understand while Prescott Valley School will make a reasonable attempt to accommodate the modifications listed above, meals from home provide the safest alternative.

Parent/Guardian Signature _____ Date: _____

Information/Instructions:

Due to Arizona Department of Education (ADE) guidelines, the Prescott Valley Charter School cannot make any diet modifications unless we have a Diet Order form completed by your Licensed Physician or Recognized Medical Authority.

Please allow at least 10 school days for accommodations to be made.

Step 1: Parents-- complete **Part I and Part II**. Identify if the child has a life-threatening food allergy, disability or special dietary need.

Step 2: Please have a Licensed Physician or Recognized Medical Authority complete **Part III** of the form. If the child has a life-threatening allergy or disability, only a Licensed Physician can complete **Part III**. For other special dietary needs a Recognized Medical Authority may complete **Part III**. All modifications must be reasonable in order to be accommodated by the Nutrition Department and Prescott Valley School.

Step 3: Parents-- Sign the **Parent Consent Signature Line** on the bottom of the form and return the completed form (after a Licensed Physician or Recognized Medical Authority completes and signs **Part III**) to your Cafeteria for processing.

Definition of Recognized Medical Authority—A recognized medical authority includes Naturopathic or Osteopathic Physician, Licensed Physician, Physician Assistant, Registered Nurse, Registered Dietician, or Nurse Practitioner.

Understand if your child's medical or health needs change at any time, it is your responsibility to notify the Nutrition Department Staff and complete a new Diet Order form with your Licensed Physician or Recognized Medical Authority.

For life-threatening allergies, meals from home provide the safest alternative.

Please contact Nutrition Services if you have any questions at (928) 772-8744 ext 3005.