Wonderland Inc.

BEATRICE MAYES INSTITUTE
A WONDERLAND INC. SCHOOL

Physician's Request for Special Dietary Accommodations

Student's Name: _____ DOB: _____

Date: _____ School Year: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

School Nurse: _____ Phone: _____

I give Health Services/ Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent/Guardian Signature: _____ Date: _____

Section A. *(To be completed by a licensed physician)*

I. Disability or severe, life-threatening food allergy
Student's Medical Condition/Disability (REQUIRED)

_____

- ☐ **Yes, continue with this section**
- ☐ **No, refer to section B**
- ☐ No Fluid Dairy Milk
- ☐ No Milk Products (yogurt, cheese, etc)
- ☐ No Milk Protein/Milk Ingredients (in baked goods, etc.)
- ☐ No Whole Eggs
- ☐ No Eggs as an ingredient
- ☐ No Wheat/Gluten
- ☐ No Peanuts
- ☐ No Tree Nuts
- ☐ No foods processed in a facility that contains nuts
- ☐ No Seafood
- ☐ No Soy
- ☐ Other *(Please list)*

_____

_____

Substitutions: _____

II. Texture Modification:

☐ Year Round ☐ Temporary: *Start* _____ *End* _____

Liquids

- ☐ *Thin (Regular Liquids)*
- ☐ *Mechanical Soft (chopped)*
- ☐ *Nectar Thick*
- ☐ *Mechanical Soft (ground)*
- ☐ *Pudding Thick*
- ☐ *Pureed (Applesauce texture)*

III. Supplement:

- ☐ *NPO* ☐ *Supplement to accompany oral diet*
- ☐ *Boost Kid Essentials 1.0* ☐ *Pediasure* ☐ *Pediasure w/ Fiber*
- ☐ *Pediasure w/ Fiber 1.5* ☐ *Other:* _____

Dosage Per Meal (REQUIRED):

_____ Breakfast _____ Lunch _____ After School Snack

**Supplements not listed above may take up to 6 weeks to be processed.*

IV. Therapeutic Diet Order: Please provide specifics below.

_____

_____

Section B. *(To be completed by a recognized medical authority)*

Food Allergy/Intolerance (NOT LIFE THREATENING)
Student without a disability but is requesting dietary accommodations. Please check one of the boxes below (REQUIRED):

☐ Allergy ☐ Intolerance ☐ Other _____

Student's allergy/intolerance to food(s) below:
*DOES NOT result in a life-threatening/anaphylactic reaction**

- ☐ *No Fluid Dairy Milk*
- ☐ *No Milk Products (yogurt, cheese, etc)*
- ☐ *No Milk Protein/Milk Ingredients (in baked goods, etc.)*
- ☐ *No Whole Eggs*
- ☐ *No Eggs as an ingredient*
- ☐ *No Wheat/Gluten*
- ☐ *No Peanuts*
- ☐ *No Tree Nuts*
- ☐ *No foods processed in a facility that contains nuts*
- ☐ *No Seafood*
- ☐ *No Soy*
- ☐ *Other (Please list)*

_____

Substitutions: _____

_____

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability and/or life-threatening food allergy or food intolerance/ allergy, as indicated.

_____
Signature of Prescribing Medical Authority *Date*

_____
Printed Name of Medical Authority

( ) - ( ) -
Phone *Fax*

_____
Address

_____

Please fax completed form to school nurse. Physician requests must be renewed each school year. Any change in accommodations must be requested in writing by physician or authorized medical authority.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. 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. This institution is an equal opportunity provider