Sacramento City Unified School District

NUTRITION SERVICES DEPARTMENT
3051 Redding Ave.●Sacramento, CA 95820-2122
(916) 277-6716●FAX (916) 277-6521
Brenda Padilla, Director

Physician's Rx for Special meals at School

(for the accommodation of severe conditions or food allergies substantially limiting major life activities or major bodily functions)

Rev. 12/02/2014

USDA Regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose conditions restrict their diets and will be provided substitutions when that need is supported by a statement ***signed by a licensed physician*** *and the condition affects a Major Life-Activity or Major Bodily Function (eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, immune or digestive function). The physician's statement must identify: □ the child's disability, □ an explanation of why the disability restricts the child's diet; □ the major life activity or major bodily function affected by the disability, □ the food or foods to be omitted from the child's diet; and □ and the foods that can be substituted.*

All requests for Special Diets will be reviewed and approved by the Nutrition Services Department. Contact number: 277-6716

PARENT

PARENT/GUARDIAN: PLEASE COMPLETE ITEMS # 1-7.
Sign and date the form, take to Doctor and return to School Nurse, Cafeteria or Nutrition Services for processing.

1. Student's Name: _____ 2. Date of Birth: _____ 3.Grade: ____ 4. School: _____

4. Home Phone # : _____ 5. Daytime Phone # : _____ 6. Other Phone: _____

7.Parent/Guardian Name: _____ Address: : _____

Signature: _____ Date: _____

PHYSICIAN

PHYSICIAN'S DIETARY STATEMENT FOR CHILDREN WITH DISABILITIES:

8. **Does the student have a disability that restricts his/her diet and limits a major life activity?** (see check boxes below)

Check one box: ☐ **Yes** If "yes", complete the remainder of the form.
☐ **No** **If "no", STOP** and complete Request for Food Substitutions at School

9. **Please check the category into which the child's disability falls**:

☐ Orthopedic impairment requiring texture modification.
☐ Metabolic Conditions or Inborne Errors of Metabolism.
☐ Neuromuscular conditions or diseases affecting the blood.
☐ Food Anaphylaxis (severe food allergy).
☐ Major bodily function: immune or digestive function
☐ Mental / Emotional / Sensory or Learning Disabilities.
☐ Other _____

MODIFICATION NEEDED:

Texture: ☐ Chopped ☐ Mechanical Soft ☐ Pureed ☐ Tube Feeding

Metabolic: ____ gm CHO ____ gm Pro ____ other

10. Describe the ***disability*** ; "physical/mental impairment" that restricts a ***major life activity, a major bodily function*** or the ***severe &/or anaphylactic reaction*** resulting from a severe food allergy, and ***why it restricts the child's diet.***

11. **Describe in detail** the diet restriction to ensure proper implementation.

12. Please Indicate foods to Omit:

13. Allergy / Modification Substitutions:

If Eggs -
☐ Omit plain eggs, only
☐ Omit all products containing eggs

If Milk / Dairy -
☐ Omit liquid milk only
☐ Omit all products containing milk
☐ Substitute juice for milk
☐ Substitute water for milk
☐ Other _____

14. Physican Name: _____

15. Medical License # : _____

16. Physician's Signature: _____

17. Date: _____ 18. Phone # : _____

19. M.D. Office Stamp:

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