

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 2022-2023

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 _____

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

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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.

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 Name (Print)

Physician Stamp (Below)

Physician Phone

Physician Signature

Date

FOR SARASOTA COUNTY SCHOOLS DISTRICT USE ONLY

Approved Declined

Nutrition Educator Name (Print)

Nutrition Educator Signature

Date