Sacramento City Unified School District

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

Physician's Rx for Special Meals at School

(not for the accommodation of food intolerances)

Rev. 7/17/2012

USDA Regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets and will be provided substitutions when that need is supported by a statement signed by a licensed physician and the disability affects a Major life-activity (eating, performing manual tasks, walking, seeing, hearing, speaking, breathing and learning. 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 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 District Dietitian (RD). Contact number: 277-6714

PARENT

PARENT/GUARDIAN: PLEASE COMPLETE ITEMS # 1-7. Print name, sign, date, take to Doctor, and return to School Nurse or Cafeteria for processing. We will only consider specific conditions for special diet requests.

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?**

Check one box: ☐ **Yes** If "yes", complete the remainder of the form.
☐ **No** **If "no", *STOP* here, a special diet is not warranted.**

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).
☐ Mental / Emotional / Sensory or Learning Disabilities.

MODIFICATION NEEDED:

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

Metabolic: ____ gm CHO ____ gm Pro ____ other

10. Describe the **disability**; "physical or mental impairment" that restricts the ***major life activity*** or the ***severe and/or anaphylactic reaction*** resulting from the severe food allergy.

11. Describe why the disability restricts the child's diet:

12. Please Indicate foods to Omit:

13. Suggested Substitutions:

14. Describe the severe and/or anaphylactic reaction resulting from the severe food allergy:

☐ Milk anaphalaxis; substitute juice for milk ☐ Milk anaphalaxis; substitute water for milk

15. Physican Name: _____

16. Medical License # : _____

17. Physician's Signature: _____

18. Date: _____ 19. Phone # : _____

20. M.D. Office Stamp: