Gilbert Public Schools
Nutrition Services Department
Special Dietary Needs Form

The attached form is required for any menu substitutions or accommodations due to special dietary needs and must be signed by a recognized medical authority (Dentists, Homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians.)

Students with Disabilities

USDA regulations require that substitutions or modifications be made in school meals for children whose disabilities restrict their diets. Food allergies that are life-threatening (resulting in anaphylactic reactions) are defined as a disability under Section 504 of the Rehabilitation Act.

Students with Non-Life Threatening Food or Other Special Dietary Needs

The Gilbert Public Schools Nutrition Services Department may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. The Gilbert Public Schools Nutrition Services Department will accommodate any reasonable request for students without a disability. However, schools are not required to make dietary modifications for children unless they have a disability. Determinations regarding dietary modifications will be made on a case-by-case basis by a Registered Dietitian employed by the Gilbert Public Schools Nutrition Services Department.

Instructions for Completing the Dietary Needs Form

Part 1 (to be filled out by parent or guardian)

- **Name of Student:** Enter the student's first and last name.
- **Date of birth:** Enter the student's date of birth (EG. May 28, 2001 = 05/28/01).
- **School:** Enter the name of the school that the student regularly attends.
- **Name of Parent/Guardian(s):** Enter the full name of the student's parent(s) or legal guardian(s).
- **Phone:** Enter the parent/guardian's daytime phone number with area code.

Part II (to be filled out by the medical authority)

- **Diagnosis:** Insert the patient's clinical diagnosis for the condition that requires dietary modifications.
- **Foods to be omitted from the child's diet:** Indicate which foods must be omitted from the child's diet for medical reasons.
- **Foods to be substituted:** Indicate appropriate substitutions for the foods which are to be omitted.
- **Special Considerations:** List any special considerations that affect the child's diet.
- **Please check:** Place a check mark next to the corresponding line for the child's condition – (life-threatening, managed by child with moderate supervision, or self-controlled by the child).
- **Medical Authority:** Print the name, address, and phone number of the medical authority completing the form.
- **Medical Authority Signature:** Signature of (Dentists, Homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians.) filling out the form and the date signed.

****PLEASE NOTE****

Please plan to send a lunch with your student until you receive verification that the special diet request has been reviewed and accommodations can be made. Our department will contact you as soon as possible.

For more information, please contact Nutrition Services at 480-497-3482.

This institution is an equal opportunity provider.

GILBERT PUBLIC SCHOOLS

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Fueling Minds Gilbert Public Schools SCHOOL NUTRITION SERVICES

Please return completed form to:
Gilbert Public Schools Nutrition Services Department/Food Service Supervisor
140 South Gilbert Road, Gilbert, AZ 85296
Fax: 480-507-1358 or email rhonda.dewitt@gilbertschools.net

Gilbert Public Schools - Nutrition Services

Special Dietary Needs Form

Part I (to be filled out by parent or guardian):

Child's name: ___________________________ School: ___________________________ Date of Birth: __________

Parent/Guardian Name: ___________________________ Phone: ( ) ___________________________

Address: ____

City: ___________________________ State: ____________________ Zip Code: ____________________

Email address: ____

Part II (to be filled out by the medical authority (Dentists, Homeopathic Physicians, Naturopathic Physicians, Nurse Practitioners, Osteopathic Physicians, Physician Assistants, and Physicians.):

Please complete the following for the above child. List all foods that should be omitted from the diet and any foods or types of foods that may be substituted. If there are any special considerations needed for meal service, please list them in the space provided below.

Diagnosis requiring diet modifications:

Foods to be omitted from child's diet:

Foods to be substituted:

Special considerations:

Please check one of the following:

- ☐ **Life threatening**
- ☐ **Managed by child with moderate supervision**
- ☐ **Self-controlled by child**

Medical Authority Contact Information:

Name: ___________________________ **Phone:** ___________________________

Address: ____

Medical Authority's Signature: ___________________________ **Date:** ____________________