Paradise Valley Unified School District • Phoenix, Arizona

| Student's Name: | Student Number: | Date of Birth: | School: |
|---|---|---|---|
| | | | |

## Medical Statement: Children with Food Allergies

Sponsors of child nutrition programs may, **at their discretion**, make substitutions for individuals who are not "handicapped," as defined in 7 CFR 15b.3(i), but who are unable to consume a food item because of medical or other special dietary needs. Such substitutions may be made only on a case-by-case basis and when supported by a statement signed by a "recognized medical authority." In such cases, "recognized medical authority" means a licensed physician, physician's assistant or nurse practitioner.

**CONSENT OF PARENT OR GUARDIAN TO RELEASE OF INFORMATION**

*Consentimiento del padre de familia o tutor legal para suministrar información*

**The undersigned parent/guardian authorizes the release and/or exchange of medical information between the school nurse and my child's health care provider as it relates to this medical condition. I understand that any medical information given or received shall remain confidential and shall be used in a professional manner.**

*El suscrito padre de familia o tutor legal autoriza el suministro o intercambio de información entre la enfermera de la escuela y el médico de mi hijo(a) con relación a esta afección médica. Entiendo que cualquier información médica que se suministre o se reciba deberá permanecer confidencial y se usará de manera profesional.*

**Signature of Parent/Guardian**
*Firma del padre de familia o tutor legal*

**Date**
*Fecha*

**Print Name of Parent/Guardian Name**
*Nombre en letra de molde del padre o tutor legal*

**Home Phone**
*Teléfono de la casa*

**Cell Phone**
*Teléfono celular*

**Work Phone**
*Teléfono del trabajo*

**Home Address**
*Dirección de la casa*

**City**
*Ciudad*

**Zip**
*Código postal (Zip*

**(THE FOLLOWING NEEDS TO BE COMPLETED BY THE CHILD'S HEALTH CARE PROVIDER ANNUALLY BEFORE THE START OF SCHOOL)**
**[21 USC §2205]**

**Diagnosis** (include description of the patient's medical or other special dietary needs that restrict the child's diet)**:**

**Foods to be Omitted and Designated Substitutions:** (Please list food(s) to be omitted and suggest substitutions.)

| Foods to be Omitted | Suggested Substitutions |
|---|---|
| | |
| | |
| | |
| | |

**Additional Information:**

**Please return completed document to:**

**Name of School Nurse**

**School Name**

**Address**

**City** **State** **Zip**

**School Telephone Number** **School FAX Number**

**Physician's Signature** **Date**

**Type or Print Physician's Name and Licensed Title**

**Address**

**City** **State** **Zip**

**Telephone Number** **FAX Number**