

Preschool Medical Statement for Meal Accommodations

Please complete the entire form before turning it into the Preschool Office. Accommodations may take 10-15 business days to begin.

Part I - To be completed by parent or guardian:

Student ID #: _____

Student's Name: (Last) _____ (First) _____ Date of Birth: ____/____/____

School Attending: _____ Preschool Teacher: _____

Parent/Guardian Name: (First and Last) _____

Parent Contact Phone Number: _____ Email: _____

Preschool students sit in a communal area for family style mealtimes. No food or drink is allowed from the outside unless with special permission from the Preschool Director. If special accommodations are needed, please speak with the preschool office directly: Phone 623-773-6675 or email preschool@pusd11.net

I give the Food & Nutrition Department permission to speak with the below named Licensed Healthcare Professional to discuss the dietary needs described below. Parent/Guardian Signature: _____ Date: _____

Part II – To be completed by the student's Healthcare Professional (An individual who is authorized to write medical prescriptions under state law. This form will be **null and void** if anyone other than the medical professional completes this portion of the form. **No exceptions.**)

Please indicate how ingestion, contact, inhalation and/or exposure to the food affects the child:

☐ Digestive Issues ☐ Excess Mucus Production ☐ Decreased Energy/Lethargy ☐ Skin Conditions ☐ Coughing/Wheezing,
☐ Itching ☐ Swelling in Oral Cavity ☐ Hives ☐ Anaphylaxis. ☐ Other: _____

Has an EpiPen been prescribed? Yes No Which allergy(ies) is the EpiPen prescribed for? _____

Foods to be OMITTED from the diet (please mark all that apply):

☐ Peanuts ☐ Tree Nuts ☐ Coconut ☐ Fish ☐ Shellfish
☐ Fluid Milk ☐ Cheese ☐ Yogurt ☐ Whole Egg (hardboiled, scrambled) ☐ French Toast
☐ Soy Milk ☐ Edamame/Tofu ☐ Soy Sauce ☐ Sesame Seed ☐ Gluten
☐ Corn Syrup ☐ Whole Corn ☐ Corn Meal/Flour ☐ Fruit: _____
☐ Other not listed (please be specific): _____

Other Ingredient: (When marked, this will severely restrict the options of the student)

☐ All Dairy Proteins (Whey, Casein, butter, etc.) ☐ All Egg Proteins (Eggs baked in, i.e. Muffins; Albumin; globulin)
☐ Soy Derivatives (soybean oil, soy lecithin, soy albumin, etc.) ☐ All Corn Additives (dextrose, dextrin, caramel color, etc.)

Foods that can be used as a substitute: _____

Texture Modification: ☐ Soft ☐ Minced/ground ☐ Pureed ☐ Other (specify): _____

Texture Modification instructions: _____

This diet request is good through the time they are preschool. A new form will be required when entering Kindergarten.

Name of Licensed Physician (please print): _____

Physician's Signature: _____ Date: _____

Phone: _____ Fax: _____ Mailing Address: _____

If any changes occur to the child's diet, please update the Food & Nutrition Office. A new form will be required.

Send completed form to Peoria Unified School District Food & Nutrition Office via fax, scan/email, or mail:

10721 N. 95th Avenue, Peoria, AZ 85345 Phone: (623) 487-5184 Fax: (623) 487-5190 Email: foodandnutrition@pusd11.net