Servicios de Alimentos y Nutrición del Distrito Escolar de Martin

(FORMA ANUAL) SOLICITUD MEDICA PARA ADAPTACIONES MEDICAS ESPECIALES SY 23/24

Distrito Escolar del Condado de Martin | Servicios de Alimentos y Nutrición 772-223-2655 ext. 58100

PADRES/GUARDIANES: Complete del 1 - 8 *(Padre/Madre/Tutor: complete la información en los espacios 1 al 8)*

1. Student's Last Name *(Apellido)*	2. Student's First Name *(Nombre del estudiante)*	3. Date of Birth *(Fecha de nacimiento)*

4. School *(escuela)*:________________ **Grade** *(grado)*_____ **Student ID#** *(número de estudiante)* ____________________

5. Which meals will the student *eat from the school cafeteria:* ¿Qué comidas *de la cafeteria* comerá el estudiante?

Breakfast (*desayuno*) Lunch (*Almuerzo*) After-School Snacks (*Merienda/Golosina*)
After-School Supper Program None – Students packs meals from home (*Nada*)

6. Parent/Guardian Name, Phone Number & Email - Nombre de Padres/Guardianes, tlf. Y email.

Name *(Nombre)*: ___________________________________ **Telephone Number** *(Teléfono)*: ______________________

Email Address – correo electrónico:_____________________________________

7. Parent Request – Pedido de los Padres:

NOTE: Physician does not need to complete form for lactose intolerance *(El médico no tiene que completar el formulario de intolerancia a la lactosa).*

☐ **Lactose Intolerance** *(Intolerancia a lactosa)*

If Lactose Intolerant, circle foods the student ***can eat at school*** *(Si tiene intolerance, circule lo que puede comer):*

Cheese *(Queso)* **Yogurt** *(Yogur)* **Pizza** *(la pizza)* ***Ice-Cream*** *(helado)* **None of these foods** *(Ninguno de estos alimentos)*

☐ **Other (Must be diagnosed by the treating physician using the back of this form)**
(Otro – debe ser diagnosticado por un médico en la parte de atrás de esta forma)

Information regarding major allergens/nutrients and carbohydrate information is available for review at
(ver informacion sobre alergenos/ nutrientes/y carbohidratos en). **www.martinschools.nutrislice.com**

8. I consent to the exchange of information between physician and school - if needed. (Doy mi consentimiento para el intercambio de información entre médico y la escuela - si es necesario).

Parent/Guardian Signature __________________________________ **Date:** ________________________________
(Firma del padre/madre/tutor) *(Fecha)*

Instructions: Please submit the completed form to cafeteria manager. ***The student must pack all meals for 10 days to allow time for the form to be processed by the district office***. Por favor complete la forma y entréguela a la manager de la cafeteria. ***El estudiante debe empacar sus comidas por 10 diás mientras la oficina del distrito procesa la forma.***
Note: Parent/Guardian is responsible for submitting a new form **annually** (or) anytime changes occur. To remove allergy restrictions, the parent/guardian must submit a Discontinuation of Diet Form to the cafeteria.
Los padres/Guardianes son responsables por completar una forma nueva todos los años o cuando un cambio suceda. Para remover las restricciones, se debe completar otra forma para discontinuar esta.

INCOMPLETE FORMS will be returned. (Formularios incompletos serán devueltos).
Please review the form for completion before submitting to the FNS office to avoid delays.

PHYSICIAN ONLY SECTION - Complete Items 9 - 17 *(Esta sección para ser completada por el medico solamente)*

9. Does the student have a Disability, Medical Condition, or Severe Food Allergy that requires a special diet?

☐ Yes, complete the remainder of this form. ☐ No, **SKIP TO #15**--> **A special diet is not required.______________**

10. Please check all food(s) to OMIT from the child's diet during the school day (not to be used as a medical history):

DAIRY
☐ Fluid Cow's Milk
☐ Cheese, Yogurt, Pizza, Ice Cream
☐ Baked goods that contain milk as an ingredient

EGGS
☐ Whole Eggs
☐ Baked goods that contain egg as an ingredient

PEANUT/ TREENUT/ SESAME
☐ Peanuts
☐ Tree Nuts
☐ Sesame

FISH/SHELLFISH
☐ Fish
☐ Shellfish

WHEAT/GLUTEN
☐ Wheat
☐ Gluten

SOY
☐ Soy

OTHER
☐ Please be specific ____

11. Please list safe food suggestions (for item(s) checked above):

____

12. Disability/Medical Condition: State the disability of the major life activity affected by the (food related) disability.
Please do not leave it blank – this question must be answered.

☐ Breathing ☐ Eating ☐ Other (please list) ______________________________________

13.Food Texture Modification (*please select one*): **SKIP TO #15**--> Texture Modification is not needed for this child.
Please specify IDDSI level [4-7]: ____

14. Regular *consistency* liquids (milk, juice) are acceptable for the above student to consume? Yes No
Comments: ____

15. Physician's Signature/ Date	**16. Physician's Stamp:**
17. Physician's Phone Number:	

Martin County School Food & Nutrition Services Department (Office Use Only)		
Received at School – *Café Mgr. Initials*	Received at FNS Office – *FNS Office*	Date Processed – *FNS Office*
Notes:		

Esta institución ofrece igualdad de oportunidades.