Perpich Arts High School

**Dietary /Modification Restriction Form**

# Student Name: Date of Birth: Grade: 11 / 12

Please list any **dietary restrictions or special diets**:

What is the medical diagnosis?

List any **allergies or food intolerances**:

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**List specific foods that can substitute for foods not allowed**:

Has student received a nutrition consultation? ❑ Yes ❑ No Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **I authorize the School District to provide special meals as described above.**

# \*Physician’s Signature: Phone Date

*or CNP/PA Signature*: Phone Date

Clinic Name/Address: Fax #:

Parent/Guardian’s Signature: Phone Date

**\* NOTE: A physician’s signature is required in order to make mandated dietary modifications and/or food substitutions due to a student’s disability.** If a student does not have a disability but has a medical condition requiring dietary modifications/substitutions, a Physician, CNP or PA may sign the form, and the Food Services will make a reasonable attempt to accommodate the request but is not mandated to do so without a disability status.

## Parent/guardian may sign the form without health provider signature if there are dietary preferences unrelated to a health condition or disability. These preferences will be taken into consideration, but Food Service is not required to make dietary modifications.

Or Send to: Perpich Center for Arts Education, High School

 6125 Olson Memorial Highway

 Golden Valley, MN 55422

 Attention: School Nurse

Please contact: Wendy Sandstrom, RN, Licensed School Nurse at 763-279-4193 for assistance.

Copies to: \_\_\_\_ Pupil Health Record \_\_\_\_ Lunch Room Staff \_\_\_\_ Food Service Director