Dear parent/guardian,

The Bedford City Schools is happy to accommodate students with special dietary needs.

To ensure that our Nutrition Services staff and School Health Services are adequately informed about your child's special diet, please complete the attached Diet Prescription for Special Meals form. Please be as detailed as possible about the level of omission of any food allergens or foods to which your child is allergic or intolerant. For example, if your student cannot have milk, indicate if the restriction is ONLY MILK or if the restriction is for ALL DAIRY PRODUCTS.

Once you have completed the form, please have it signed by your physician or physician's representative. Only a licensed physician or physician's representative may sign the medical statement for students with special dietary needs. Upon completion of the form, turn it into your school's health office for distribution to the appropriate staff. This will assure that the Bedford Schools have the necessary medical orders on file to address your child's dietary needs.

If your child's diet changes for any reason please, make sure that the Diet Prescription Form is updated by the physician and given to the school health office. This will enable the school nurse to notify the appropriate staff about any changes to your child's diet.

Thank for your assistance.

Sincerely,

School Health Services
Bedford City School District

"Building Tomorrow Together"

BEDFORD CITY SCHOOL DISTRICT

PROUDLY SERVING BEDFORD • BEDFORD HTS. • WALTON HILLS • OAKWOOD

DIET PRESCRIPTION FOR SPECIAL MEALS

School Year: _____

It is imperative that this form is completed ANNUALLY by you AND your child's healthcare provider and returned to your child's school health clinic in order for our dietary team to make any menu modifications and/or substitutes.

PHYSICIAN SIGNATURE IS REQUIRED ON THIS FORM

MUST BE COMPLETED BY THE PARENT/GUARDIAN:

Name of Student:_____ Grade:_____ School:_____

Parent/Guardian Name:_____ Date:_____

Parent/Guardian Signature:_____ Phone Number:_____

MUST BE COMPLETED BY THE PHYSICIAN:

Medical Reason for Diet Modification:_____

Is this a life threatening allergy? YES_____ NO_____

Diet Prescription: _____

Foods to be omitted:_____

Foods to be substituted:_____

Please attach a copy of the diet instruction sheet if available.

I certify that the above named student needs special food in school as described above.

Physician Name (please print):_____ Date:_____

Physician Signature:_____ Phone Number:_____

PLEASE COMPLETE THIS RETURN THIS FORM TO YOUR STUDENT'S HEALTH CLINIC.