

**SPRINGFIELD PUBLIC SCHOOLS HEALTH SERVICES
504 DIETARY PLAN**

SCHOOL:
STUDENT NAME:
GRADE:

DATE OF BIRTH:
STUDENT NUMBER:
TEACHER:

Section 504 of the Rehabilitation Act of 1973 assures handicapped students access to school meal service, even if special meals are needed because of their handicap.

“Handicapped student” means any student who has a physical or mental impairment which substantially limits one or more life activities; has a record of such impairment, or is regarded as having such impairment.

If special meals are needed and requested, certification from a medical doctor must (1) verify that special meals are needed because of the handicap, and (2) prescribe the alternate foods and forms needed.

1. Handicap/Diagnosis: _____

2. Why /How does handicap/diagnosis restrict the student’s diet? _____

3. What is the major life activity affected by the student’s handicap/diagnosis? _____

Food Intolerance: _____

Food Allergy: _____

Type of reaction to food: i.e., hives, GI distress, possible anaphylaxis, other- please identify:

Is the food allergy life-threatening (anaphylaxis)? __yes __no

Which specific food(s) cause anaphylaxis? _____

Food(s) to be omitted from Student’s Diet: **YES** **Food(s) to be substituted:**

Milk: liquid		
Milk: whey or casein protein allergy		
Is milk baked into foods OK?		
Dairy Products: yogurt, cheese, other – please specify:		
Eggs: Soft Scrambled, fresh cooked, raw – please specify:		
Are eggs baked into foods OK?		
Meat/meat alternates – please specify:		
Grains, grain products, gluten – please specify:		
If gluten: is this an intolerance or due to Celiac Disease?		
Fruits, vegetables, please specify:		
Peanuts, tree nuts, all nuts, please specify:		
Other Dietary Information/Instructions:		

Licensed Medical Provider’s Signature (MD, DO, PA, NP)

Date

Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____

Will your child consume school meals? Daily _____ Sometimes _____ Rarely _____ Never _____

PARENT SIGNATURE: _____ DATE: _____

***Above signature by parent/guardian to also serve as authorization to discuss diagnosis/health with authorizing physician.**

FORM IS REQUIRED TO BE UPDATED EACH SCHOOL YEAR

Copy to be sent to SPS Dietitian in Nutrition Services & to the Nutrition Services Site Manager

Revised 07 08 2022