WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT
Food Services Department
750 Bissell Ave, Richmond CA 94801
Tel: (510) 307-4580 Fax: (510) 233-1805

2017-2018 MEDICAL STATEMENT – REPORTE MÉDICO

for CHILDREN REQUIRING **DIETARY RESTRICTIONS** or **MODIFICATIONS**
due to ALLERGIES or CHRONIC DISEASES
para Niños quienes requieren Restricciones o Modificaciones Dietéticas
a causa de Alergias o Enfermedades Crónicas

NAME OF STUDENT/*Nombre del Estudiante*	BIRTHDATE/ *Fecha de Nacimiento*
NAME OF PARENT or GUARDIAN/*Nombre del Padre, Madre o Tutor*	PHONE NUMBER/*Número de Teléfono* ( )

MEDICAL AUTHORITY PLEASE COMPLETE IN FULL:

Esta porción tiene que ser completada por el Médico o Persona Autorizada:

FOOD ALLERGY or CHRONIC DISEASE:

DIET PRESCRIPTION and TEXTURE MODIFICATION:

(Please describe in detail to assure proper implementation)

☐ REGULAR ☐ CHOPPED ☐ GROUND ☐ PUREED

FOODS OMITTED AND SUBSTITUTIONS:

(Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach additional information.)

FOODS TO BE OMITTED	SUGGESTED SUBSTITUTIONS

A PHYSICIAN OR OTHER RECOGNIZED MEDICAL AUTHORITY MUST SIGN THIS FORM

In this case, "RECOGNIZED MEDICAL AUTHORITY" includes a Nurse Practitioner or a physician's assistant.
Un Médico o alguna autoridad médica reconocida necesita firmar este formulario. En este caso, "Autoridad Médica Reconocido" incluye a enfermeras con licencia para practicar medicina o el/la asistente al médico.

SIGNATURE OF PHYSICIAN or OTHER RECOGNIZED MEDICAL AUTHORITY	PRINTED NAME	TITLE
	EMAIL ADDRESS	
	PHONE NUMBER	TODAY'S DATE

FOOD SERVICES OFFICE ONLY/ *Unicamente para la Oficina de Servicios de Comida*

DATE RECEIVED	REVIEWED BY	COPY SENT TO SITE & DATE
	DATE	COPY SENT TO CK & DATE

FORM MUST BE RESUBITTED WHEN ALLERGY CHANGES

Revised 8/2017