

# MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY NEEDS

◆ Please use black or blue ink only (NO PENCIL). Must complete all fields and return to School Nurse. ◆

### PART A: STUDENT INFORMATION

STUDENT FIRST NAME	STUDENT LAST NAME	DATE OF BIRTH	AGE	
1. Does the child have a disability* as defined below. Please specify the major life activity affected by the disability in the space provided (i.e. eating, performing manual tasks, caring for one's self, walking, hearing, speaking, breathing, and/or learning). <b>If yes, complete Part B of this form and have it signed by a Licensed Physician.</b>			Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. If the child is not disabled, does the child have special nutritional or feeding needs? If yes, complete Part B of this form and have it signed by a recognized Medical Authority.			Yes <input type="checkbox"/>	No <input type="checkbox"/>

### PART B: SPECIAL DIETARY NEEDS

<i>Diagnosis/Special Dietary Needs-Note:</i> <i>Severe/LIFE THREATENING food allergies (Anaphylaxis) require a signature by a Licensed Physician.</i>			
<b>Foods To Be Avoided:</b> <b>Medical Restrictions - Food Allergies OR Food Intolerances. Please check all that apply</b>			
<input type="checkbox"/> Milk or Dairy	<input type="checkbox"/> Lactose Intolerant/Lactose-free Milk	<input type="checkbox"/> Wheat/Gluten	
<input type="checkbox"/> Peanuts or Peanut Butter	<input type="checkbox"/> Soy	<input type="checkbox"/> Fish	
<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Eggs	<input type="checkbox"/> Shellfish	
<input type="checkbox"/> Other (please specify): _____			
Food to be Substituted (Acceptable Alternatives): _____			
Texture Modification: Please check one (if applicable)			
<input type="checkbox"/> Chopped (bite-size)	<input type="checkbox"/> Ground	<input type="checkbox"/> Blended	<input type="checkbox"/> Pureed

<i>Physician/Medical Authority Printed Name</i>	<i>Signature</i>	<i>Phone Number</i>	<i>Date</i>

<i>Parent/Guardian Printed Name</i>	<i>Signature</i>	<i>Phone Number</i>	<i>Date</i>

<input type="checkbox"/>	<b>YES</b>	Parent/Guardian accepts accommodations offered and his/her child will be participating in the Child Nutrition Program and any other program offered within the child's school. <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Dinner
<input type="checkbox"/>	<b>NO</b>	Parent/Guardian declines accommodations offered and his/her child will not be participating in the Child Nutrition Program and any other program offered within the child's school.

<i>Parent/Guardian Signature</i>	<i>Date</i>

\* Under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. The definition included children with severe food allergies. The term child with a "disability" under Part B of the Individuals with Disabilities Education Act (IDEA) means a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who by reason thereof, needs special education and related services.

## Physician's Statement for Children with Disabilities and Special Dietary Needs

USDA regulations 7CFR Part 15b require substitutions or special dietary accommodations in school meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions in foods when that need is supported by a statement from a licensed physician. The physician's statement must identify:

- Child's Disability
- Major life activity affected by the disability
- Food or foods to be omitted from the child's diet
- Food or foods that must be substituted

The **CMSD MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY NEEDS** form is adapted from the USDA guidance: [Accommodating Children with Special Needs: Guidance for School Food Service Staff](#), and may be used to obtain the required information from the physician and/or medical authority (see reference below)

### Managing Severe/Life Threatening Food Allergies with Anaphylactic Reactions

***The school food service authority is not required to make food substitutions for children with non-severe food allergies and food intolerances, who do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA.***

The school food service authority may choose to make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Determinations are made on a case-by-case basis. This provision covers those children who have food intolerances or allergies but do not have life-threatening reactions. In this case, A Medical Authority (licensed physician, physician's assistant, registered nurse, nurse practitioner or registered dietitian) can complete and sign the **CMSD MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY NEEDS**. The completed and signed form must be sent to the School Nurse.

### Other Special Dietary Needs (Religious Restrictions)

If there is no known allergy, food intolerance or disability, but the parents request that a specific food be eliminated for religious reasons, the school food service authority may choose, at their discretion, to make a food substitution, but is not required to provide a substitution. In this case, the parent shall obtain Request for Meal Substitution for Religious Reasons form from the school food service manager, complete, sign and return the form to the food service manager at the school.

\* References: Accommodating Children with Special Needs: Guidance for School Food Service Staff, United States Department of Food and Nutrition Service, Fall 2001 <http://www.fns.usda.gov/cnd/Guidance/default.htm>

# SPECIAL MEALS PRESCRIPTION FORM

◆ Please use **black** or **blue** ink only (NO PENCIL). Must complete all fields and return to School Nurse. ◆

Student Name: \_\_\_\_\_ Student ID: \_\_\_\_\_

School Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Disability: <input type="checkbox"/> Disabled (Federal Policy: as determined by physician) <input type="checkbox"/> Non-disabled (school district policy)	
Disability or medical condition:	
<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Food Intolerance
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Autism/PDD	<input type="checkbox"/> Failure to Thrive
<input type="checkbox"/> Galactosemia	<input type="checkbox"/> None
<input type="checkbox"/> Kidney/Renal Disease	<input type="checkbox"/> Other _____
Description of Condition Requiring Special Diet: _____	
Special Diet: _____	
<i>(Check all that apply)</i> <input type="checkbox"/> Diabetes <input type="checkbox"/> Reduced Calorie <input type="checkbox"/> Increased Calorie <input type="checkbox"/> Modified Texture	
Date Effective: _____	To: _____

PHYSICIAN/MEDICAL AUTHORITY SIGNATURE SECTION	
<input type="checkbox"/>	I certify that the above named student needs special meals prepared as described above because of the student's disability.
<input type="checkbox"/>	I certify that the above named student would benefit from special meals as described above, however this child is not disabled. It is up to the discretion of Food and Child Nutrition Services if and for what conditions they will provide substitutions.

\_\_\_\_\_  
Physician/Medical Authority's Printed Name \_\_\_\_\_ Office Phone Number \_\_\_\_\_ Date

_____ Physician/Medical Authority's Signature	Physician's/Medical Authority Stamp →  <b>** Stamp must be present</b>
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FCNS OFFICE USE ONLY	
Reviewed By: _____	Approved By: _____
CC:	
<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Special Education
<input type="checkbox"/> Executive Director FCNS	<input type="checkbox"/> School Nurse
<input type="checkbox"/> Central Kitchen Facility	<input type="checkbox"/> Other _____
<input type="checkbox"/> School Principal	<input type="checkbox"/> Cafeteria
<input type="checkbox"/> Physician	<input type="checkbox"/> Nutritionist