

## Medical Statement for Students with Special Nutritional Needs for School Meals

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school. See "Guidance for Completing Medical Statement for Students with Special Nutritional Needs for School Meals" for help in completing this form.

### PART A (To be completed by Parent/Guardian)

Name of Student: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Student ID # \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Will student eat breakfast provided by the school cafeteria? Will student eat lunch provided by the school cafeteria? Will the student eat a snack provided by the After School Snack Program?

Yes  No

Yes  No

Yes  No

Printed Name of Parent/Guardian: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Phone number(s): \_\_\_\_\_  
(Work) (Home) (Cell)

Email Address: \_\_\_\_\_

What concerns do you have about your student's nutritional needs at school?

What concerns do you have about your student's ability to safely participate in mealtime at school?

Does the student have an identified disability and an Individualized Education Program (IEP) or 504 Plan?

Yes  No

If Yes and you have concerns about nutritional needs, have a licensed physician complete Part B, page 2, of this form and sign it. Return completed form to \_\_\_\_\_.

If No and you have concerns about nutritional needs, have a licensed physician or recognized medical authority complete Part B, page 2, of this form and sign it.

Return completed form to \_\_\_\_\_.

**NOTE: Special dietary needs for students without an IEP or 504 Plan are accommodated at the discretion of the Child Nutrition Administrator and policies of the school district.**

Parental/Guardian Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PART B (To be completed by Licensed Physician)**

Student Diagnosis or condition:	Check major life activities affected: <input type="checkbox"/> Walking <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Speaking <input type="checkbox"/> Breathing <input type="checkbox"/> Working <input type="checkbox"/> Learning <input type="checkbox"/> Other _____ <input type="checkbox"/> Performing manual tasks <input type="checkbox"/> Caring for self (including eating)
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Specify any dietary restrictions or special diet instructions for school meals:

Designate consistency requirements for food: <input type="checkbox"/> Clear Liquid <input type="checkbox"/> Pureed <input type="checkbox"/> Full Liquid <input type="checkbox"/> Mechanical Soft <input type="checkbox"/> Blenderized liquid <input type="checkbox"/> No change needed	Designate consistency requirement for liquids: <input type="checkbox"/> Thin <input type="checkbox"/> Spoon-thick <input type="checkbox"/> Nectar-like <input type="checkbox"/> No change needed <input type="checkbox"/> Honey-like
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List any foods causing food *intolerance* that should be avoided: \_\_\_\_\_

List any foods causing food *allergies* that should be avoided: \_\_\_\_\_

If student has **life threatening allergies\***, check appropriate box(es):     ingestion     contact     inhalation  
 \* Students with life threatening food allergies must have an emergency action plan in place at school.

For *any* special diet, list specific foods to be omitted and substitutions; you may attach a separate care plan.

a. Foods To Be Omitted	b. Recommended Substitutions

Indicate any other comments about the child's eating or feeding patterns, including tube feeding if applicable:

**If a nutritional/feeding care plan has not been developed prior to completion of this form an additional assessment is required, please refer student for feeding and nutritional assessment in your community. School-based personnel do not routinely have instrumentation and/or training for a comprehensive nutrition and feeding assessment.**

Signature of Physician/Medical Authority*	Printed Name	Phone Number	Date
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\* A licensed physician's signature is required for students with a disability. For students without a disability, a licensed physician or recognized medical authority must sign the form.

**PART C (To be completed by Child Nutrition Services)**

Child Nutrition Services Notes:

CN Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_