Student Name:

Guidance for Completing the Medical Statement for Students with Special Nutritional Needs for School Meals

Parent/Guardian:

The *Medical Statement for Students with Special Nutritional Needs for School Meals* helps schools provide meal modifications for students who require them. Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals to your child while at school.

Your participation in this process is very important. The sooner you provide this signed and completed form to your child's school, the sooner the School Nutrition Program or school staff can prepare the food your child requires. Your signature is required for your school to take action on the medical statement. The school staff cannot change food textures, make food substitutions, or alter your child's diet at school without all the information filled in on this form.

Please follow the steps below to get started:

1) Complete all items of **PART A** of the Medical Statement.
2) Take the Medical Statement to your child's pediatrician or family doctor and have him/her complete **PART B**.
3) Return the properly signed Medical Statement to your child's teacher, principal, nurse, Special Education case manager, or Section 504 case manager, School Nutrition Administrator, or the school staff person who gave you the blank form.
4) Ask the school when a team, including you and the school system's School Nutrition Administrator, will meet to consider the information provided on the form. You may invite people from the community who are knowledgeable about your child's feeding and nutrition issues to the meeting. These would be people who could help school staff design a school mealtime plan for your child, like your child's pediatrician, nurse, speech-language pathologist, occupational therapist, registered dietitian or personal care aide.

Physicians and Medical Authorities:

This form helps schools provide meal modifications for students who require them. Completion of all items will streamline efficient care of the student.

The school cannot change food textures, make food substitutions, or alter a student's diet at school without a proper statement from you. Meal modifications are implemented based on medical assessment and treatment planning and must be ordered by a licensed physician or recognized medical authority.

Please consider the following as you complete **PART B** of the Medical Statement:

1) Complete all items of **PART B**. *(Note: 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. Recognized medical authorities include physicians, physician assistants, and nurse practitioners.)*

2) Be as specific as possible about the nature of the child's disability and life activities that the disability limits. In the case of food allergy, **please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).**

3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications, or other dietary restrictions, please refer the child/family to the appropriate feeding, nutrition, or allergy specialists for completion of the Medical Statement. Schools do not routinely have instrumentation and/or staff trained for a comprehensive nutrition and feeding assessment and must partner with community providers to meet a student's special feeding and nutrition needs.
4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to the school.
5) Consider being available to consult with the child's school team as it implements the feeding/nutrition care plan.

PLEASE SEND COMPLETED and SIGNED FORMS TO:
Mooresville Graded School District
School Nutrition Services, Nutritionist
574 W. McLelland Ave.
Mooresville, NC 28115
Phone: (704) 658-2639 F:704-664-4906
sdeneen@mgsd.k12.nc.us

MAY CONTACT WITH QUESTIONS:

Kim Mccall RD, LDN - kmccall@mgsd.k12.nc.us
Shelly Deneen, DTR – sdeneen@mgsd.k12.nc.us

Diet Order

Mooresville Graded School District

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?
☐ Yes ☐ No

Will student eat lunch provided by the school cafeteria?
☐ Yes ☐ No

Will the student eat a snack provided by the After School Snack Program?
☐ 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 the School Nutrition Department and the School Nurse.

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 the School Nutrition Department.

NOTE: Special dietary needs for students without an IEP or 504 Plan are accommodated at the discretion of the School 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.

IMPORTANT: If you are submitting a new diet order or diet order change, please allow 10 business days to process. Please provide meals for your child, until you have heard from our office that this diet order has been processed. The School Nutrition Department will follow the physician's diet order as long as your child is enrolled in MGSD or until the diet order is released or changed by the parent and physician.

Parent/Guardian Signature: _____ Date:_____

Student Name:

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Parent/Guardian:

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Please follow the steps below to get started:

1) Complete all items of **PART A** of the Medical Statement.
2) Take the Medical Statement to your child's pediatrician or family doctor and have him/her complete **PART B**.
3) Return the properly signed Medical Statement to your child's teacher, principal, nurse, Special Education case manager, or Section 504 case manager, School Nutrition Administrator, or the school staff person who gave you the blank form.
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Physicians and Medical Authorities:

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The school cannot change food textures, make food substitutions, or alter a student's diet at school without a proper statement from you. Meal modifications are implemented based on medical assessment and treatment planning and must be ordered by a licensed physician or recognized medical authority.

Please consider the following as you complete **PART B** of the Medical Statement:

1) Complete all items of **PART B**. *(Note: 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. Recognized medical authorities include physicians, physician assistants, and nurse practitioners.)*

2) Be as specific as possible about the nature of the child's disability and life activities that the disability limits. In the case of food allergy, **please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).**

3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications, or other dietary restrictions, please refer the child/family to the appropriate feeding, nutrition, or allergy specialists for completion of the Medical Statement. Schools do not routinely have instrumentation and/or staff trained for a comprehensive nutrition and feeding assessment and must partner with community providers to meet a student's special feeding and nutrition needs.
4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to the school.
5) Consider being available to consult with the child's school team as it implements the feeding/nutrition care plan.

Student Name:

PART B (To be completed by Licensed Physician)

Student Diagnosis or condition:	Check major life activities affected: ☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing ☐ Working ☐ Learning ☐ Other _____ ☐ Performing manual tasks ☐ Caring for self (including eating)

Specify any dietary restrictions or special diet instructions for school meals:

Designate route of delivery of foods:	Designate consistency requirements for food:	Designate consistency requirement for liquids:
☐ Oral Feeding ☐ Tube Feeding Formula Name _____ Additional Instructions for Tube Feeding: Flush with _____cc's of water after feeding. Check residual: ☐ Yes ☐ No If greater than _____cc's of water, hold feeding. ☐ Special Mealtime Equipment _____ _____	☐ Pureed ☐ Ground ☐ Finely Chopped (approx. Pea Size 1/4 " sized pieces) ☐ Chopped (approx. ½" sized pieces) ☐ Other ☐ No Texture Modification	☐ Thin ☐ Spoon-thick ☐ Nectar-like ☐ No Liquid Modification ☐ Honey-like

FOOD INTEROLANCES

Does the student have a *FOOD INTOLERANCE* (i.e. lactose intolerance)? ☐ Yes ☐ No

If *YES* please list specific *FOOD INTOLERANCE* _____

If *YES* please list the appropriate substitutions _____

Can the student have foods made with small amounts of the ingredient (ie. Bread that has milk as an ingredient)?

☐ Yes ☐ No

If YES please specify appropriate foods that may be tolerated _____

FOOD ALLERGIES

Does the student have a *FOOD ALLERGY*? ☐ Yes ☐ No

If *YES* please check all food groups AND specify foods that must be omitted?

☐ Peanuts/Nuts _____

☐Dairy (including cheese, yogurt, ice cream) _____

☐Eggs _____

Student Name:

☐Fish _____

☐Milk (if different from lactose intolerance) _____

☐Wheat (Note: includes many of our bread, baked, and breaded protein/meat items) _____

☐ Other _____

☐ Soy _____ Does it include Soy Oil? ☐ Yes ☐ No

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. **Further Specify Foods To Be Omitted**	b. **Specify 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

* 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 School Nutrition Services)

School Nutrition Services Notes:

SN Administrator Signature: _____ **Date:** _____