

Tangipahoa Parish School System
Child Nutrition Programs

59656 Puleston Road · Amite, Louisiana 70422 · Phone 985-748-2480 · Fax 985-748-2487

Special Accommodations with School Meal Programs

School Year 2022 - 2023

This document is in effect until medical authority revises special diet.

Please fax completed form to 985-748-2487

Student's Name: _____ Age: _____ DOB: _____ Student # _____

School: _____ Grade: _____ Homeroom: _____

Parent's Name: _____ Parent's E-mail _____

Address: _____ Telephone: _____

(Street or P.O. Box)

City

Zip

1. Does the child have a disability or IEP/IAP on file? Yes or No If yes, describe the major life activities affected by the disability. _____
2. If the child is not disabled does the child have special nutritional or feeding needs? Yes or No _____
3. Does your child have an Epi-Pen for specific food or foods? Yes or No If yes, please list food or foods. _____

List Disability/Medical Condition: _____

Diet Prescription (check all that apply):

- | | | |
|--|---|---|
| € Diabetic: Carbohydrate Counting OR | <i>Carbohydrate Grams</i>
_____ Breakfast
_____ Lunch | <i>Carbohydrate Grams</i>
_____ AM Snack
_____ PM Snack |
| € Lactose Intolerance (eliminate fluid milk):
Other dairy allowed: cooked cheese, etc.
Please document substitute for Fluid Milk: | _____ Yes
_____ Juice | _____ No
_____ Water |
| € Calorie Count: _____ Breakfast Calories
_____ Lunch Calories | _____ Lunch Calories | _____ AM/PM Snack |
| € Texture Modification: _____ Diced
_____ Pureed (check one): | _____ Chopped
_____ Nectar-like | _____ Ground
_____ Honey-like |
| | <input type="checkbox"/> Milk-like | <input type="checkbox"/> Pudding-like |
| € Other Diet Prescription: _____ | | |
| € Religious Reason: _____ | | |

FOOD INTOLERANCE

(Diarrhea, Bloating, Headaches, Nausea, Rashes)

Level I – eliminate intolerable food only

- € Milk (fluid form only) – cheese allowed
Substitute: Juice Water
- € Milk and Dairy Products
- € Eggs
- € Wheat
- € Soy
- € Other: _____

FOOD ALLERGY

(Will omit ALL foods that contain any of these items checked)

Level II – eliminate products with food allergen

- Milk history of inhalation reaction
- Eggs history of inhalation reaction
- Fish history of inhalation reaction
- Shellfish history of inhalation reaction
- Tree Nuts history of inhalation reaction
- Peanuts history of inhalation reaction
- Wheat history of inhalation reaction
- Soy history of inhalation reaction
- Other: _____

I certify that the student named above needs special diet accommodations prepared as described related to the student's medical condition.

Office Address: _____

Office Telephone: _____
Office Fax: _____

Date _____

Licensed Physician/Recognized Medical Authority Signature ****SIGNATURE REQUIRED TO PROCESS****

Guidelines and Requirements For Special Accommodations with School Meal Programs

These guidelines and requirements have been established to ensure the safety of students when medically necessary menu change must be implemented.

- Per USDA, a new diet prescription form **MUST** be completed annually regardless if any changes occur.
- Diet prescription forms must be filled out completely.
- Diet prescription form **MUST** be signed by a Physician or recognized Medical Authority.
- Diet Prescription forms will not be altered unless the Diet Prescription Form is updated by the physician.
- Diabetic Meal Plans: include the number of carbohydrates for each meal and snack.
- Food Allergens: include specific information regarding foods to omit and substitute.
- If the student cannot have fluid milk, please document appropriate substitute. We can provide bottled water, or a 4oz juice, as a substitution.
- Diet restrictions due to religious beliefs- parent/guardian **MUST** complete the current year Diet Prescription Form stating the specific food to eliminate.
- Diet Prescription Forms **MUST** be completed before implemented at the school site.
- Menu substitutions will be provided at the discretion of the Child Nutrition Services Office according to current food availability.
- Please allow 5 days for processing in the Central Office. Parent/Guardian will need to provide breakfast and/or lunch during this time. Please fax, mail or deliver the form to the **Tangipahoa Parish Child Nutrition Department, 59656 Puleston Road, Amite LA 70422, Phone # (985-748-2480) Fax # (985-748-2487).**
- If the student has a **Food Intolerance (digestive system response) – Level I**, Check the foods that apply. The indicated allergen foods will be eliminated from the student’s meal tray if its whole form. (Example: The student has an intolerance to eggs, the student will not be served whole eggs such as scrambled eggs, hard boiled eggs, etc.)
- If the student has **Food Allergy (immune system response) – Level II**, check the foods that apply. The indicated allergen foods will be eliminated from the student’s meal tray in its whole form as well as any food that contains the allergen food as an ingredient. (Example: The student has an allergy to eggs, the ingredient listing will be reviewed for eggs and any foods containing eggs will be eliminated from the student’s meal tray). Please indicate if the student has a history of inhalation induced anaphylaxis reaction to the specified allergen.
- Confirmation of process completion will be sent to parent/guardian via contact number/email provided.

Non Discrimination Statement: This explains what to do if you believe you have been treated unfairly.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or (2) Fax: (833) 256-1665 or (202) 690-7442; or (3) Email: program.intake@usda.gov

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