Medical Referral Form for Modified School Meals

Current Federal regulations require that requests for modified meals and special diets be authorized by a medical doctor (USDA policy memo 84-6 and FNS 783-2). For each student requesting modified school meals, this form is to be completed and maintained with the student's health records at school.

1. **Note to school personnel: Please complete the identifying information.**
2. **Send this form. And a return envelope to the student's parent/guardian.**

TO BE COMPLETED BY SCHOOL PERSONNEL

SCHOOL_____ DATE_____

STUDENT_____ BIRTHDATE_____

PARENT/GUARDIAN_____ PHONE_____

ADDRESS_____

SPECIAL DIET/MODIFIED MEALS REQUESTED_____

_____

_____

3. **Note to parent/guardian: Federal regulations require this information. Your assistance in completing this form is essential and appreciated.**

TO BE COMPLETED BY PARENT/GUARDIAN

Is the special diet request in section 1 correct? YES_____ NO_____ If not, what is the correct diet for the student? _____

Signature of Parent/Guardian_____Date_____

*****If modified meals <u>are not</u> required by the student, return this form to the school.**

*****If modified meals <u>are</u> required, send this form and the return envelope to the student's medical doctor for completion of section 3.**

I,_____(parent name) give my permission for the cafeteria supervisor and/or the school nurse to contact my child's doctor,_____ at _____(phone number) to clarify anything related to my child's modified diet request.

Signature of Parent/Guardian_____Date_____

4. **Note to physician: School Nutrition Services personnel have been requested to serve this student modified meals in the child nutrition programs. To insure that, in so doing. The student's medical requirements are being met appropriately; we request that you complete the form on this page. Should you have any questions, contact the Director of Nutrition Services at (502) 570-3035 for clarification.**

TO BE COMPLETED BY PHYSICIAN

1. **Is the diet modification designated in section 1. appropriate at this time? YES_____NO_____**
   Comments_____
2. **If this student requires texture-modified meals, specify: Not applicable_____**
   Ground Foods_____
   Pureed Foods_____
3. **Are there foods which should <u>not</u> be served to this student? YES_____ NO_____**
   If Yes, List foods which should not be served_____
   If yes, also list suggestions for alternative foods which may be served to this student

_____

4. **Does the student have a disability? YES_____ NO_____**
   If yes, describe the major life activities affected by the disability.

_____

_____

If yes, does the student have special nutritional or feeding needs? YES_____ NO_____

5. **If the student is not disabled, does he/she have special nutritional or feeding needs?**
   YES_____ NO_____
6. **List any allergies or food intolerances to avoid: _____**

_____

Which of these allergies is life threatening? _____

_____

Additional recommendations: _____

_____

Signature of Physician_____Date_____

Office Address_____Zip_____Phone_____

RETURN THIS FORM IN THE ENVELOPE PROVIDED TO THE SCHOOL NUTRITION SITE MANAGER. YOUR PROMPT ATTENTION AND ASSISTANCE ARE APPRECIATED.