MEDICAL STATEMENT FOR STUDENTS REQUIRING SPECIAL MEALS

Child Nutrition Services
Kansas City Public Schools

This statement **MUST** be updated when there is a change in the diet order.

Student Last Name	MI	First Name
Parent Name	Student Grade	
Parent Telephone	School Attending	
Student ID	Student Date of Birth	

I hereby give my permission for the school staff to follow the stated nutrition plan below. I give my permission for child nutrition services to contact the doctor if questions arise.

_____ _____
Parent/Guardian Date

For Physicians Use (to be completed by a licensed physician)

Identify and describe disability, or medical conditions, including allergies that require student to have a special diet.

_____

_____

Describe the major life activities affected by the student's disability.

_____

Diet Prescription (check all that apply):

Diabetic: ☐ Calorie Level (attach meal plan) ☐ Carb Counting (attach meal plan)

☐ Modified Texture and/or liquids

☐ Calorie – Controlled: ___ __calorie level

☐ Other (describe):_____

☐ Food Allergy: (Please list each allergy): _____

***Please be specific, if the student has a milk allergy is it fluid milk only or all milk products, if a child has an egg allergy, is it just fresh eggs baked/cooked in products is ok.

If student has a food allergy, is this a life-threatening allergy? ☐ Yes ☐ No

Food Omitted and Substitutions:
If foods are listed to be omitted from the diet, **specifics** on foods to substitute must be provided.
(see back)

Child Nutrition, Attention: Dietitian
2901 Troost
Kansas City, MO 64109
Fax: 816-418-7431

Foods to Omit:

_____

_____

_____

_____

_____

Foods to Substitute:

_____

_____

_____

_____

_____

Indicate Texture: ☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

Indicate thickness of liquids: ☐ **Regular** ☐ **Nectar** ☐ **Honey** ☐ **Pudding**

Special Feeding Equipment: _____

Additional Comments:

_____

_____

_____

I certify that the above named student needs special school meals prepared or served as described above because of the student's disability or chronic medical condition.

_____ _____

Licensed Physician or Recognized Medical Authority Date

Name, including Credentials: _____ Phone: _____

Type or Print

Fax: _____

_____

Signature of Preparer or Other Contact

Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990.

"Disabled person" means any person who has a physical or mental impairment, which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

"Physical or mental impairment" means (1) any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sensory organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic skin, and endocrine or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to such diseases as orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction, and alcoholism.

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

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