## Medical Plan of Care for School Food Service (Students with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B require substitutions or modifications in school program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The school <u>may</u> choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).
- The school food authority <u>may</u> choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. If available, this will be indicated in Part 2. A parent/guardian or **recognized medical authority** (physician, physician assistant, or nurse practitioner) may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

		only substitution being requested, complete <u>Fait Fait</u>	<u>a 2 Offiy</u> .		
·	y Parent/Guardian (all requ	ests for special dietary needs)			
Child's Name		Date of Birth	M F		
Name of School/Center/Program		Grade Level/Classroom			
Parent's/Guardian's Name		Address, City, State, Zip Code			
( )	( )				
Home Phone	Work Phone				
		g special dietary needs only			
	es not make milk substitutes a	available to students with non-disabling special dietary	needs. Do not		
☐ School/school district pro	vides	as a milk substitute to students w	ith non-disabling		
or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district.					
	isabling medical or special die	etary need that restricts intake of fluid milk? Yes	No 🗌		
List medical or special dietar	y need (e.g., lactose intolerar	nce or for cultural or religious beliefs):			
Medical Authority or Paren	t/Guardian Signature:	Date	9:		
Part 3: To be completed b	y Physician/Medical Author	rity			
Disability/Special	•				
Does the child have a <b>disab</b>					
If Yes,	ijor life activities affected by the	no disability			
	ijor lile activities affected by ti	ne disability.			
Does the child's disabili	ty affect their nutritional or fe	eding needs? Yes ☐ No ☐			
	,				
	disability*, does the child ha	ave special nutritional or feeding needs? Yes	No 🗌		
If the child has a disability	or special dietary/feeding r	need, please complete Part 4 of this form and have ed physician/recognized medical authority.	e it signed and		
Stamped with the office ha	ille allu auuress or a licelis	eu physician/recognizeu medicai authority.			
Part 4: To be completed b	y Physician/Medical Author	rity			
Diet Order					
	such as food allergies, intoler	ances or restrictions:			

Special Dietary Needs January 2010

List specific foods to be substituted (Substitution cannot be made u	ınless sec	tion is completed):		
List foods that need the following change in texture. If all foods ne	ed to be p	repared in this manne	r, indicate "All."	,
Cut up/chopped into bite sized pieces:				
Finely Ground:				
Pureed: List any special equipment or utensils needed:				
Indicate any other comments about the child's eating or feeding pa	ttorno			
indicate any other comments about the child's eating of reeding pa	illems.			
Physician's Name and Office Phone Number		Office Stamp		
Physician/Medical Authority's Signature		Date		
		T =		
Part 5: Parent Signature		Date		
Part 6: School Nutrition Program Signature		Date		
· air oi coileai iraaniich i rogram cignatare		Jaio		
Health Insurance Portability and Accountability Act Waiver				
In accordance with the provisions of the Health Insurance Portabili	ty and Acc	ountability Act of 1996	and the Fami	ly Educational
Rights and Privacy Act, I hereby authorizeprotected health information of my child as is necessary for the specific production of the specific produ	ecific purpo	(medical autionse of Special Diet info	nority) to releas ormation to	se sucn
(school/progra freely exchange the information listed on this form and in their reco	am) and I c	onsent to allow the ph	nysician/medica	al authority to
necessary. I understand that I may refuse to sign this authorization	n without ir	mpact on the eligibility	of my request	for a special
diet for my child. I understand that permission to release this information has already been released. My permission to release to				
This information is to be released for the specific purpose of Specia				, ,
The undersigned certifies that he/she is the parent, guardian or replegal authority to sign on behalf of that person.	resentativ	e of the person listed	on this docume	ent and has the
Parent/Guardian Signature:		Date:		
(Signing this section is optional, but may prevent delays by allowing	g us to spe	eak with the physician	)	
Please have parent/guardian review form annually and initial/date if a new form signed by the Physician/Medical Authority.	no change	es are required. Any	changes requir	e submission of
Parent confirmed no change in diet order Date	Da	ate	Date	
Date Date Date	<del></del>	Date		Date
A copy of this form should be kept by the School Food Service student's medical information regarding dietary needs with sch			s school nurse	es to share
Special Dietary Needs			January 2010	