



Muscogee County School District

School Nutrition Program

Instructions for Special Dietary Needs Prescription Form

MCSD School Nutrition Program will make modifications and substitutions to the regular school meals for a student **with a disability that restricts their diet**. The MCSD Special Dietary Needs Prescription Form **must** be completed and signed by a physician for a student with a disability before the school cafeteria can provide any modifications or substitutions. The completed form must be provided to the School Nutrition Program, including the school cafeteria manager and the Nutrition Specialist. The school cafeteria staff will prepare the meal along with the other meals being served that day.

Follow these steps to ensure a student with a disability requiring special nutrition needs is served the proper diet in the school breakfast, lunch and snack programs:

1. Have the Special Dietary Prescription Form completely filled out. The prescription must be completed and signed by a licensed physician if the student has a disability.
2. Regulations require that this documentation be on file for each student who receives a special meal. This documentation must be on file in the school cafeteria and nurses' office, and with the Nutrition Specialist.
3. Work with the cafeteria manager and the Nutrition Specialist to know what foods will be served at school.
4. The Nutrition Specialist, school nurse, or other health professional may suggest that the special dietary needs be included in the Individual Education Plan (IEP) or the 504 Plan, as appropriate.

MCSD School Nutrition Program will try to accommodate special dietary needs for students without a disability. Such determinations are made on a case-by-case basis by the Nutrition Specialist, and must be supported by the same Special Dietary Prescription Form signed by an authorized licensed medical authority.

For further information, including definitions of disability and of other special dietary needs, and school's responsibility, please visit USDA's Student Nutrition website at <http://www.fns.usda.gov/cnd/Guidance/>.

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Return completed form to:
School Nutrition Program

MUSCOGEE COUNTY SCHOOLS SPECIAL DIETARY NEEDS/FOOD ALLERGY

Please print neatly. Por favor, escriba legible

School Year:

PART A Parent / Guardian: Complete Items 1 - 15 (Padre/madre/tutor: complete la información en los espacios 1 al 15)

1) Student ID# (Numero de estudiante)	2) Student's Last Name (Apellido)	3) Student's First Name (Nombre del estudiante)	4) Date of Birth (Fecha de nacimiento)

5) School (Escuela)	6) Grade (Grado)	7) Meals Eaten at School (Los alimentos que su niño(a) consumirá en la escuela)
		☐ Breakfast (Desayuno) ☐ Lunch (Almuerzo) ☐ Snack (Meriendao) ☐ None (Nada)

Parent/Guardian Name & Contact Information (Nombre & Información del contacto)

8) Name (Nombre)	9) Phone Number (Teléfono)	10) Mailing Address, City, State, Zip (Dirección postal, ciudad, estado, código postal)

11) E-mail Address (PRINT NEATLY)
Dirección electrónica (IMPRIMA)

12) Parent Requests that are not due to a medical disability. Please Note: School Nutrition may attempt to accommodate cultural/personal preferences but are not required by law to do so. These accommodations depend on product availability on the daily serving line. ☐ Vegan ☐ Vegetarian ☐ No Pork ☐ No Beef ☐ Other

13) Does the student have an identified disability (IEP or 504 Plan)? ¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)? ☐ IEP ☐ 504 ☐ No

14) I consent to the exchange of information between the Healthcare Provider and district/school personnel, as needed.
(Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)

Parent / Guardian Signature (required for processing)
(Firma del padre/madre/tutor - requerido para ser procesado)

X

Date
(Fecha)

15) Parent/Guardian: It is REQUIRED that this completed form is returned to MCSD School Nutrition Program, including the school cafeteria manager and the Nutrition Specialist, unless the child has a healthcare plan or an IEP/ 504 Plan on file. If one of these exists, please provide it to the Nutrition Specialist.

(Padre/madre/tutor: Se REQUIERE que este formulario completo se devuelva al Programa de Nutrición Escolar de MCSD, incluido el administrador de la cafetería de la escuela y el Especialista en Nutrición, a menos que el niño tiene un plan de atención médica o un plan IEP/504 registrado. Si existe alguno de estos, favor de proporcionarlo al Especialista en Nutrición.)

*Information regarding major allergens and nutrient/carbohydrate information are available for review at <https://muscogee.k12.ga.us/c/Divisions/OperationsAndFacilities/SchoolNutrition>
(Ver información sobre alérgenos y nutrientes/carbohidratos en <https://muscogee.k12.ga.us/c/Divisions/OperationsAndFacilities/SchoolNutrition>)

PART B COMPLETED BY HEALTHCARE PROVIDER (MD, APRN, PA, OD) ONLY: Complete Items 16 – 21

(16 al 21 - Esta sección para ser completada por el médico solamente.)

16) Does the student have a disability, medical condition, or severe food allergy warranting a special diet? ☐ Yes ☐ No

If "YES", specify disability below. If "no", a special diet is not warranted. A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

Disability (specify) _____

Describe major life activities affected ☐ Eating ☐ Learning ☐ Digestion ☐ Other (specify) _____

Student Diagnosis or Condition:

☐ Lactose Intolerance: Available options to substitute are: ☐ Lactose Free Milk ☐ Soy Milk Mark if the student can eat: ☐ Cheese ☐ Yogurt

For the following diagnosis, section 17 below must be completed to identify which foods must be omitted due to the identified condition:

☐ Food Intolerance ☐ Food Allergy ☐ Life Threatening Food Allergy

17) Please check all food(s) to omit from the child's meals while at school due to the above noted disability:

DAIRY Anaphylactic ☐ Yes ☐ No

- ☐ All food/beverages with milk listed as an ingredient including baked goods
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Yogurt
- ☐ Fluid Milk. Substitute with ☐ Lactose-free milk ☐ soy milk ☐ water

EGG Anaphylactic ☐ Yes ☐ No

- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ All food items with egg listed as an ingredient including baked goods

WHEAT / GLUTEN Anaphylactic ☐ Yes ☐ No

- ☐ Recipes with wheat listed as an ingredient
- ☐ Recipes with Gluten (wheat, barley, rye, triticale) listed as an ingredient

PEANUTS OR TREE NUTS Anaphylactic ☐ Yes ☐ No

- ☐ Peanuts ☐ Tree Nuts

CORN Anaphylactic ☐ Yes ☐ No

- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn listed as an ingredient (corn syrup, corn starch, etc.)

SOY Anaphylactic ☐ Yes ☐ No

- ☐ Recipes with any soy listed as an ingredient

FISH OR SHELLFISH Anaphylactic ☐ Yes ☐ No

- ☐ Fish ☐ Shellfish

OTHER Anaphylactic ☐ Yes ☐ No

- ☐ Other, specify if it is a cooked ingredient or when consumed fresh

18) Name of Epinephrine device at school: _____ ☐ None Does the student use an Epinephrine device? ☐ Yes ☐ No

19) Food Texture Modifications: Is student allowed to have any food/drink by mouth? ☐ Yes ☐ No

Food Texture Modifications that are required due to the noted disability in section #16: ☐ Regular ☐ Pureed ☐ Minced & Moist (Ground) ☐ Soft & Bite-sized (Chopped)

Thickened liquids: ☐ Thin (regular liquids) ☐ Slightly thick ☐ Mildly thick (Nectar) ☐ Moderately thick (Honey) ☐ Extremely thick (pudding)

20) Other Nutrition Requirements due to documented disability in Section #16: Please specify:

21) Healthcare Provider Information Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.

Healthcare Provider Signature

Date

Medical Office Stamp

X

Healthcare Provider Printed Name