Medical Plan of Care for Greene County School Nutrition Program
(Students with Disabilities that require Special Dietary Needs)
Page 1 is to be completed by Parent/Guardian.
Page 2 is to be completed by a licensed physician/physician assistant/nurse practitioner.
Please return completed forms to: Greene County School Nutrition Program Office

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

- USDA regulations 7 CFR Part 15B require substitutions or modifications in school nutrition program meals for children whose **disability** restricts their diet. The purpose of this form is for your licensed physician/physician assistant/nurse practitioner to document this disability.
- Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability", as well as other dietary restrictions which substantially limit one or more major life activities.
- Greene County School Nutrition Program provides information based on product label information provided to us and cannot guarantee that food products served are not processed in plants that also process nuts or other allergens.
- Labeled foods will only note the presence of eight major allergens: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat and soybeans. **While efforts will be made to avoid other allergens, Greene County Schools cannot guarantee that labels will disclose all possible allergens.**

Part 1: To be completed by Parent/Guardian

Child's Name:		Date of Birth:	Gender: M F
Name of School:		Grade Level/Classroom:	
Parent's/Guardian's Name:		Address, City, State, Zip Code:	
( )	( )		
Home Phone	Cell Phone	Email Address:	

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize_____(medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to Greene County Schools and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on_____(date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian, or official representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____
(Signing this section is optional, but may prevent delays in allowing us to speak with the physician)

Part 2: Parent Signature	Date:

Part 3: Disability/Special Dietary Needs (To be completed by Physician/Physician Assistant/Nurse Practitioner)
Does the child have a **disability**? Yes ☐ No ☐

If Yes,
Please identify the disability, describe the major life activity or activities affected by the disability, and describe the nature/severity of the impact of the disability on a major life activity or activities.

Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

If the child has a disability that requires a special dietary/feeding need, please have a licensed physician complete Part 4 of this form.

Part 4: Diet Order (To be completed by Physician/Physician Assistant/Nurse Practitioner)

List any dietary restrictions **required** as a result of the student's disability (list specific foods to be omitted):

Labeled foods will only note the presence of eight major allergens: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat and soybeans. While efforts will be made to avoid other allergens, the Greene County Schools cannot guarantee that labels will disclose all possible allergens.

List specific foods to be substituted (substitution cannot be made unless section is completed):

List foods that need the following change in texture. If all foods need to be prepared in this manner, 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 patterns:

Physician/Physician Assistant/Nurse Practitioner Name (Printed)	Office Address and Phone Number:
Physician/Physician Assistant/Nurse Practitioner Signature	Date:

Greene County Schools, School Nutrition Program Office, 101 East Third Street, Greensboro, GA 30642