



REQUEST FOR SPECIAL MEALS AND/OR ACCOMMODATIONS

The Flagler County Schools Food and Nutrition Services provides modified meals, accommodations, and milk substitutions for children with special dietary needs due to a disability. Due to the complicated nature of some issues regarding feeding children with special dietary needs, all requests must be signed by a licensed physician (MD or DO) or a physician’s assistant (PA) or an advanced registered nurse practitioner (APRN) and must be approved by the Food and Nutrition Services Dietitian, prior to any accommodations being made.

PARENT/GUARDIAN

A Parent/Guardian who wishes to request a special meal, accommodation, or milk substitution for their child, must complete the required steps below prior to the request being granted. Accommodations will be made on a case-by-case basis and are based on the Physician diagnosis as specified in the Medical Request for Special Meals and/or Accommodations Form. It is recommended that parents complete the required steps at least **3 weeks** prior to the start of school to ensure Food and Nutrition Services has everything in place to make the necessary accommodations. If there is a delay in obtaining the necessary documentation from the medical authority, parents are strongly encouraged to send a safe meal from home to ensure their child’s needs are met.

IMPORTANT: Requests for special meals and/or accommodations must be renewed every two school years.

STEPS TO BE COMPLETED (Check upon completion)

STEP 1: Submit **Completed** Medical Request for Special Meals and/or Accommodations Form

- Fax the form to 386-437-7570

STEP 2: The Food and Nutrition Services Dietitian will contact you to discuss your child’s meal plan and to go over the submitted Medical Request for Meal Substitution Form

STEP 3: Submit a cancellation form when the student no longer requires an accommodation

- Accommodation Cancellation Date: _____

Parent/ Guardian Signature: _____ Date: _____



FLAGLER COUNTY SCHOOLS
MEDICAL REQUEST FOR SPECIAL MEALS AND/OR ACCOMMODATIONS
(Medical requests for special meals and/or accommodations must be renewed every 2 school years)

1. Student's School	2. Student's Name	3. Date of Birth	
4. Parent/ Guardian Name		5. Parent/Guardian Contact Home: Cell/Work:	
6. Home Address		7. Parent/Guardian Email	
<p>I authorize this information to be shared with the school nurse and/or other administrative staff for purposes of implementing the diet prescription and to accommodate the student in all school activities. I also give permission for my child's medical authority to further clarify the diet prescription on this form if requested to do so by the district administrative staff.</p> <p>Parent/Guardian Signature: _____ Date: _____</p>			
<p>The remainder of this form must be completed by a State of Florida Licensed Medical Authority - physician (MD or DO) or a physician's assistant (PA) or an advanced registered nurse practitioner (APRN) or a Registered Dietitian (RD)</p>			
<p>8. State the disability or medical condition requiring a special meal, accommodation, or fluid milk substitute (e.g., Celiac disease, food allergy or food intolerance)</p> <p>* Does the disability or medical condition affect major life activities or major bodily functions? Select one of the following:</p> <p><input type="checkbox"/> This condition affects major life activities (included but not limited to caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working). This condition is a disability.</p> <p><input type="checkbox"/> This condition affects major bodily functions (including but not limited to functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions). This condition is a disability.</p> <p><input type="checkbox"/> This condition does not affect major life activities or major bodily functions. This condition is not a disability.</p>			
<p>9. Provide a detailed Diet Prescription that meets the student's medical condition. The prescription must include foods to be omitted and substituted:</p> <ul style="list-style-type: none"> • Foods to be omitted _____ • Foods to be substituted _____ 			
<p>10. As applicable, select the restricted food components as part of the student's diet prescription:</p> <p><input type="checkbox"/> Milk - as a beverage (student will receive soymilk unless a soy allergy is present)</p> <p><input type="checkbox"/> Milk products - such as cheese, ice cream, yogurt or as an ingredient in baked goods (e.g., muffins), entrees (e.g. pizza)</p> <p><input type="checkbox"/> Eggs - whole egg: the white, and the yolk (e.g., hard-boiled, patty or scrambled)</p> <p><input type="checkbox"/> Egg products - as an ingredient in baked goods, entrees or breading (e.g., chicken nuggets)</p> <p><input type="checkbox"/> Wheat <input type="checkbox"/> Peanuts <input type="checkbox"/> Treenuts <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Soy <input type="checkbox"/> Sesame</p>			
<p>11. Indicate texture <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed</p>			
12. Signature of Medical Authority & Credentials		13. Printed Name	
		14. Telephone #	15. Date
16. Signature of Food and Nutrition Services Dietitian		17. Date parent notification letter sent of approved accommodation	
18. Signature of Cafeteria Manager		19. Date Diet Prescription Implemented	