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 <u>Part 1 and 2 only</u>.

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Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)						
Child's Name		Date of Birth	M	F		
Name of School/Center/Program		Grade Level/Classroom	Grade Level/Classroom			
Parent's/Guardian's Name		Address, City, State, Zip Code				
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Home Phone	Work Phone					
Part 2: Request for milk substitution for non-disabling special dietary needs only School/school district does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2.						
School/school district provides as a milk substitute to students with 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.						
Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk? Yes No List medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):						
Medical Authority or Parent/Guardian Signature: Date:						
Medical Authority or Parent/Guardian Signature: Date:						
Part 3: To be completed by Physician/Medical Authority						
Disability/Special Dietary Needs						
Does the child have a disability? Yes \(\square\) No \(\square\)						
If Yes, Please describe the major life activities affected by the disability.						
Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐						
If the child does not have a disability* , does the child have special nutritional or feeding needs? Yes No (*These accommodations are optional for schools to make)						
If the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.						
Part 4: To be completed by Physician/Medical Authority						
Diet Order	and an facility in the					
List any dietary restrictions,	such as food allergies, intolera	ances or resunctions:				

Parent confirmed no change in diet order Date Date Date	List specific foods to be substituted (Substitution cannot be made unless section is completed):						
Cut up/chopped into bite sized pieces: Finely Ground: Puread: List any special equipment or utensils needed: Indicate any other comments about the child's eating or feeding patterns: Physician's Namo and Office Phone Number Office Stamp Physician's Namo and Office Phone Number Office Stamp Physician's Namo and Office Phone Number Date Part 5: Perent Signature Date Part 5: School Nutrition Program Signature Date Date Date Health Insurance Portability and Accountability Act Walve: In scoordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Phracey Act. I hereby authorize protected health information of my child as is necessary for the specific purpose of Special Diet information to (school/crogram) and ic consent to allow the hysician/medical authority to feetly exchange the information listed on this form and in their records concerning my child with the school program as necessary. Lunderstand that I may refuse to sign this authorization without impact on the eligibility of my recuester for a special diet for my child. I understand that may refuse to sign this authorization without impact on the eligibility of my recuester for a special diet for my child. I understand that permission to release this information will expire on (cate). This information is to be released. My permission for release this information will expire on (cate). This information is to be released for the specific purpose of Special Diet information. Parent/Guardian Signature Eligining this section is onlined, but may prevent delays by allowing us to speak with the physician's equipment of a new form signed by the Physician's delay authority. The protection is onlined, but may prevent delays by allowing us to speak with the physician's equipment of a new form signed by the Physician's delay authority. The protection is onlined, but may prevent delays by allowing us to speak with the physician's equipment of a new form signed by the P							
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A copy of this form should be kept by the School Food Service and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service.