FOOD ALLERGIES

Menu modifications are made for students with food intolerances. Please have your doctor fill out the Special Diet Request Form when substitutions or alteration to the menu are required to meet you child (s) health condition. We encourage parents/guardians to update this form each year due to changes in dietary needs.

Cafeteria managers must follow the most recent form on file from doctor.

Individuals with severe food allergies or strict diets should confirm the ingredient and nutrient information on the actual product label. The cafeteria manager can assist with this information.

Special dietary request must be supported by a medical statement, signed by a recognized medical authority.

It is very important that the appropriate personnel are notified and the proper medical statement is completed to address any request.

The food service director or the cafeteria manager will notify parents and guardians of the process for requesting meal modifications to accommodate a child's disability, and arrange for an impartial hearing process to resolve grievances related to requests for modifications based on a disability. The food service director and cafeteria manager will provide a revised menu to the school nurse and parents, and guardians each month. For additional information as needed. For example, if the substitutions needed for accommodations fall outside of the USDA meal pattern, the form must be signed by state state-licensed healthcare professional with prescriptive authority or a registered dietitian.

(see forms below)

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Guidance for Completing the Medical Statement for Students with Special Dietary Needs

PART A - PARENT/GUARDIAN

The *Medical Statement for Students with Special Dietary Needs* helps schools provide meal modifications for students with medical needs. Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare provider. Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals and snacks to your child while at school.

Your participation in this process is very important. The sooner you provide this signed and completed form to your child's school, the sooner the School Nutrition Program and their staff can prepare the food your child needs. Your signature is required for your school to take action on the Medical Statement.

Follow these steps to get started:

1) Complete all sections of PART A of the Medical Statement.
2) Take the Medical Statement to your child's pediatrician or family doctor/nurse practitioner/physician's assistant/dietician and have him/her complete PART B.
3) **RETURN THE FULLY COMPLETED MEDICAL STATEMENT WITH SIGNATURES FROM BOTH PARENT/GUARDIAN AND MEDICAL AUTHORITY, TO YOUR CHILD'S PRINCIPAL, SPECIAL EDUCATION CASE MANAGER OR SECTION 504 CASE MANAGER, SCHOOL NUTRITION ADMINISTRATOR, OR THE SCHOOL STAFF PERSON WHO GAVE YOU THE BLANK FORM.**
4) Ask the school when a team, including you, the school system's School Nutrition Administrator and others, will meet to consider the information provided on the form.

PART B – RECOGNIZED MEDICAL AUTHORITIES *(Licensed physician, physician assistant, nurse practitioner, dietician)*

A Recognized Medical Authority's signature is *required* for students with a disability. Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare providers. Meal modifications are implemented based on medical assessment and treatment planning and ***must be ordered by a recognized medical authority.***

Please consider the following as you complete **PART B** of the Medical Statement:

1) Complete all sections of **PART B**. Completion of all items will streamline efficient care of the student at school.
2) **Be as specific as possible about the nature of the student's physical or mental impairment, its impact on the student's diet and major life activities that are affected. In the case of food allergy, please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).**
3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications, or other dietary restrictions, please refer the child/family to the appropriate health care professional for completion of the assessment. Schools do not routinely have instrumentation and/or staff trained for a comprehensive nutrition and feeding assessment and must partner with community providers to meet a student's unique feeding and nutrition needs.
4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to the school.
5) Consider being available to consult with the student's mealtime planning team as it implements the feeding/nutrition care plan.

PART C – SCHOOL NUTRITION ADMINISTRATOR and IEP/504 REPRESENTATIVE

Please consider the following as you complete **PART C** of the Medical Statement:

Signature of the School Nutrition Administrator and 504 Coordinator or IEP Case Manager/EC Program representative indicates the medical statement has been received, reviewed, and a plan to address the student's unique mealtime needs is being developed/implemented.

USDA Nondiscrimination Statement

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Mail Stop 9410
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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Medical Statement for Students with Special Dietary Needs

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school. See *"Guidance for Completing Medical Statement for Students with Special Dietary Needs"* (previous page) for help in completing this form.

PART A *(To be completed by **PARENT/GUARDIAN**)*

STUDENT INFORMATION	**Last Name:**	**First Name:**	**Middle Name:**	**Date of Birth**
	School:		**Grade**	**Student ID#**
SELECT the school-provided meals and/or snacks in which this student will participate:	☐ School Breakfast Program ☐ National School Lunch Program ☐ Afterschool Snack Program			
PARENT/GUARDIAN CONTACT INFORMATION	**Printed Name of PARENT/GUARDIAN:**			
	Mailing Address:	**City:**	**State:**	**Zip Code:**
	Work Phone: / **Home Phone:**	**Mobile Phone:**	**Email:**	
Please describe the concerns you have about your student's nutritional needs at school:				
Please describe the concerns you have about your student's ability to safely participate in mealtime at school?				

Does the student already have an Individualized Education Program (IEP)?
☐ YES ☐ NO

Does the student already have a 504 Plan?
☐ YES ☐ NO

***NOTE:** Unique mealtime needs for students without an IEP, 504 or disability, but with general health concerns, are addressed within the meal pattern at the discretion of the School Nutrition Administrator and policies of the school district.*

PARENT/GUARDIAN Consent	**Parent/Guardian Signature**	**Date**

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your principal, Special Education case manager or Section 504 case manager, School Nutrition Administrator, or the school staff person who gave you the blank form.

STUDENT NAME: | STUDENT ID#:

PART B *(To be completed by a **RECOGNIZED MEDICAL AUTHORITY**, i.e., Licensed physicians, physician assistants, nurse practitioners, and dentist)*

Describe the student's physical or mental impairment:	**Explain how the impairment restricts the student's diet:**

Major life activities affected: *Select all that apply.*

☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Performing manual tasks
☐ Learning ☐ Breathing ☐ Self-Care ☐ Eating/Digestion
☐ Other *(please specify):*

Is this a Food Allergy? ☐ YES ☐ NO

Is this a Food Intolerance? ☐ YES ☐ NO

If student has life threatening allergies* check appropriate box(es):
**Students with life threatening food allergies must have an emergency action plan in place at school.*
☐ Ingestion ☐ Contact ☐ Inhalation

Specify any dietary restrictions or special diet instructions for accommodating this student in school meals:

For *any* special diet, list specific foods to be omitted and the recommended substitutions. *(You may attach a separate care plan)*

Foods to be Omitted →	Recommended Substitutions	Foods to be Omitted →	Recommended Substitutions

Designate safest consistency requirement for FOOD:

☐ Pureed ☐ Mechanical Soft ☐ Ground ☐ Chopped
☐ Other *(please specify):*

Designate safest consistency requirement for LIQUIDS:

☐ Clear Liquid ☐ Full Liquid ☐ Nectar-thick ☐ Honey-thick ☐ Pudding-thick
☐ Other *(please specify):*

Other comments about the child's eating or feeding patterns, including tube feeding if applicable:

***NOTE* If your assessment of the child does not yield sufficient data to fully complete the above sections applicable to the student's mealtime needs, please refer the child/family to the appropriate health care professional for completion of the assessment.**

Signature of Recognized Medical Authority*	Printed Name	Phone Number ( )	Date

** A recognized medical authority in Kentucky includes licensed physicians, physician assistants and nurse practitioners.*

PART C *(To be completed by SCHOOL DISTRICT ADMINISTRATORS)*

School Nutrition Administrator's Signature: **Date:**

IEP/504 Coordinator Signature: **Date:**

NOTES: *(School Nutrition or other School Program staff)*