Medical Statement for Students with Special Nutritional Needs for School Meals

Harnett County Schools P.O. Box 1029 Lillington, NC 27546 910-893-8151
Send a copy of the completed form to: Child Nutrition Department

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 Nutritional Needs for School Meals" for help in completing this form.

☐ Original to School Nutrition ☐ Copy to Teacher ☐ Copy to School Nurse

PART A (To be completed by Parent/Guardian)

Name of Student: (Last) _____ (First) _____ (Middle) ____

Date of Birth _____ Student ID # _____ School _____ Grade _____

SELECT the school provided meals and/or snacks in which this student will participate:	☐ School Breakfast Program ☐ Afterschool Snack Program ☐ National School Lunch Program

Printed Name of Parent/Guardian: _____

Mailing Address: _____ City: _____ State/Zip: _____

Phone number(s): (Work)_____ (Home)_____ (Cell)_____

Email Address: _____

What concerns do you have about your student's nutritional needs at school?

What concerns to you have about your student's ability to safely participate in mealtime at school?

Does the student 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 with the meal pattern at the discretion of the School Nutrition Administrator and policies of the school district.

Parental/Guardian Consent: I agree to allow my child's health care provider and school personnel to communicate as needed regarding the information on this form.

Parent/Guardian Signature:_____ Date:_____

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

Student Diagnosis or Condition:
☐ Food Allergy ☐ Food Intolerance
☐ Life Threatening Allergy (Check Appropriate Boxes): ☐ Ingestion ☐ Contact ☐ Inhalation
☐ Disability (Specify): _____ Major Life Activities Affected: _____
☐ Other (Specify): _____ Finger Food 1"- 2"

Designate safest consistency requirements for **food**:
☐ Pureed ☐ Mechanical Soft ≤ ¼"
☐ Cut/Bite-Sized ¼"- ½" ☐ Finger Food 1"- 2"
☐ No Change Needed ☐ Other (Specify)
_____

Designate safest consistency requirement for **liquids:**
☐ Clear Liquid ☐ Pudding Thick
☐ Full Liquid ☐ No Change Needed
☐ Honey Thick ☐ Other (Specify)
☐ Nectar Thick _____

Allergy/Intolerance Specifications:
Provide any appropriate substitutions. If needed, a separate care plan can be attached to this document.

Check **ALL** That Apply

DAIRY
☐Fluid Milk ☐ Yogurt
☐Cheese ☐ Ice Cream
☐Recipes with milk as an ingredient.
☐Recipes/food products with any dairy listed as an ingredient.

EGG
☐Whole egg such as scrambled or boiled.
☐Recipes/food products with any egg listed as an ingredient.

SOY
☐Recipes/food products with any soy listed as an ingredient.

WHEAT
☐Recipes/ food products with any wheat listed as an ingredient
☐ Gluten (includes: wheat, oat, barley or rye)

NUTS
☐ Peanuts ☐ Tree Nuts
☐ Other: _____

SEAFOOD
☐ Fish ☐ Shellfish
☐ Other: _____

OTHER Items to be Omitted
Specify: _____

Indicate any 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 Physician/Medical Authority*	Printed Name	Phone Number	Date

* A recognized medical authority in N.C. includes licensed physicians, physicians assistants and nurse practitioners.

PART C (To be completed by SCHOOL DISTRICT ADMINISTATORS)

Child Nutrition Services Notes:

CN Administrator Signature: _____ Date: _____

IEP/504 Coordinator Signature:_____ Date: _____

Guidance for Completing the Medical Statement for Students with Special Nutritional Needs for School Meals

Parent/Guardian:

The *Medical Statement for Students with Special Nutritional Needs for School Meals* helps schools provide meal modifications for students who require them. Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals to your child while at school.

Your participation in this process is very important. The sooner you provide this completed form to your child's school, the sooner the Child Nutrition Program or school staff can prepare the food your child requires. The school staff cannot change food textures, make food substitutions, or alter your child's diet at school without all the information filled in on this form.

Please follow the steps below to get started:

1) Complete all items of **PART A** of the Medical Statement.
2) Take the Medical Statement to your child's pediatrician or family doctor and have him/her complete **PART B**.
3) Return the Medical Statement to your child's school nurse.
4) Ask the school when a team, including you and the school system's Child Nutrition Administrator, will meet to consider the information provided on the form. You may invite people from the community who are knowledgeable about your child's feeding and nutrition issues to the meeting. These would be people who could help school staff design a school mealtime plan for your child, like your child's pediatrician, nurse, speech-language pathologist, occupational therapist, registered dietitian or personal care aide.

Physicians and Medical Authorities:

This form helps schools provide meal modifications for students who require them. Completion of all items will streamline efficient care of the student.

The school cannot change food textures, make food substitutions, or alter a student's diet at school without a proper statement from you. Meal modifications are implemented based on medical assessment and treatment planning and must be ordered by a licensed physician or recognized medical authority.

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

1) Complete all items of **PART B**. *(Note: A licensed physician's signature is required for students with a disability. For students without a disability, a licensed physician or recognized medical authority must sign the form. Recognized medical authorities include physicians, physician assistants, and nurse practitioners.)*
2) Be as specific as possible about the nature of the child's disability and life activities that the disability limits. 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 feeding, nutrition, or allergy specialists for completion of the Medical Statement. 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 special 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 child's school team as it implements the feeding/nutrition care plan.