Medical Statement for Students with Unique Mealtime Needs for School Meals

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 Unique Mealtime Needs for School Meals"* (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 ☐ Afterschool Supper Program ☐ Fresh Fruit & Vegetable 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

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**

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's teacher, principal, nurse, 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, and nurse practitioners)*

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 ☐ Other *(please specify):*
☐ Learning ☐ Breathing ☐ Self-Care ☐ Eating/Digestion

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 ☐ Other *(please specify):*
☐ Ground ☐ Chopped

Designate safest consistency requirement for LIQUIDS:

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

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 N.C. 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)*