

School Nutrition Department Medical Statement and Diet Prescription for Meals at School

This form is for students who are and are not defined as "handicapped." A handicapped person means any person who has a physical or mental impairment, which substantially limits one or more major life activities, has record of such impairments, or is regarded as having such impairments (7 CFR Part 15b and FNS Instruction 783-2). All sections of the form will need to be completed by a licensed physician if the student is diagnosed with a "handicap" per Federal law 7 CFR Part 15b and FNS Instruction 783-2 or one of the following medical authorities: physician, &/or physician assistant, nurse practitioner, registered/licensed dietitian if the student is not "handicapped," but is unable to consume food(s) because of medical or other special dietary needs. The first section ("Describe the student's handicap and the major life activity(s) affected by it") does not have to be completed by the appropriate medical authority when a student is not diagnosed "handicapped".

Student's Name: _____ DOB: _____ Ht: _____ inches cm Wt: _____ lbs kg

School: _____ Grade/Teacher: _____

Diagnosis: _____

Describe the student's "handicap" and the major life activities affected by it: _____

Please list any dietary restrictions or special diet: _____

Please list any allergies or food intolerances to avoid. Please indicate the child's reaction to this food. _____

Please list the food(s) that may be substituted in the diet: _____

Physician recommended diet:

_____ Nothing by mouth (NPO) *Prescription provided to family for formula supplement / Formula provided for school feeds by parent. Initial: _____

_____ By mouth (PO) Type Diet: Regular () Chopped () Pureed ()

Liquids:

Regular _____ Thickened _____ / Thickened Consistency: Nectar _____ Honey _____ Pudding _____

_____ Formula Supplement to school meal (ORAL ONLY)

_____ Formula G-Tube Feed

Name of Formula _____ (Substitute allowed? Yes / No)

Amount at each feeding _____

Time(s) to be fed _____

Amount of water _____ CC

Amount of water to flush _____ CC

Type of G-Tube Feeding: Bolus _____ Slow Drip _____ Pump _____ / Pump Setting: _____

Swallow study done? Yes No CIRCLE ONE (If yes, please attach if available and indicate Date: _____/_____/_____)

Other information regarding the diet: _____

Signature of the M.D. or Authorized Medical Authority

Date

Telephone #

Address of the Medical Office

Parent's Signature (*Initial formula line above)

Date

Telephone #