UCPS School Nutrition Services

407 N. Main St. Suite 100, Monroe, NC 28112

Medical Statement for Students with Special Nutritional Needs for School Meals

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

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.

PART A (To be completed by Parent/Guardian)

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

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

Will student eat breakfast provided by the school cafeteria?	Will student eat lunch provided by the school cafeteria?	Will the student eat a snack provided by the After School Snack Program?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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 identified disability and an Individualized Education Program (IEP) or 504 Plan?

☐ Yes ☐ No

If *Yes* and you have concerns about nutritional needs, have a licensed physician complete Part B, page 2, of this form and sign it. Return completed form to _____.

If *No* and you have concerns about nutritional needs, have a licensed physician or recognized medical authority complete Part B, page 2, of this form and sign it.

Return completed form to _____.

NOTE: Special dietary needs for students without an IEP or 504 Plan are accommodated at the discretion of the Child 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 discuss information on this form.

Parent/Guardian Signature: _____ Date:_____

N.C. Department of Public Instruction Child Nutrition **Services** Revised
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PART B (To be completed by Licensed Physician)

Student Diagnosis or condition:	Check major life activities affected: ☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing ☐ Working ☐ Learning ☐ Other _____ ☐ Performing manual tasks ☐ Caring for self (including eating)

Specify any dietary restrictions or special diet instructions for school meals:

Designate consistency requirements for food:		Designate consistency requirement for liquids:	
☐ Clear Liquid	☐ Pureed	☐ Thin	☐ Spoon-thick
☐ Full Liquid	☐ Mechanical Soft	☐ Nectar-like	☐ No change needed
☐ Blenderized liquid	☐ No change needed	☐ Honey-like	

List any foods causing food *intolerance* that should be avoided: _____

List any foods causing food *allergies* that should be avoided: _____

If student has **life threatening** allergies*, check appropriate box(es): ☐ ingestion ☐ contact ☐ inhalation

* Students with life threatening food allergies must have an emergency action plan in place at school.

For *any* special diet, list specific foods to be omitted and substitutions; you may attach a separate care plan.

a. Foods To Be Omitted	b. Recommended Substitutions

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

If a nutritional/feeding care plan has not been developed prior to completion of this form an additional assessment is required, please refer student for feeding and nutritional assessment in your community. School-based personnel do not routinely have instrumentation and/or training for a comprehensive nutrition and feeding assessment.

Signature of Physician/Medical Authority*	Printed Name	Phone Number	Date

* 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.

PART C (To be completed by Child Nutrition Services)

Child Nutrition Services Notes:

CN Administrator Signature: _____ **Date:** _____