

SPECIAL DIETARY NEEDS MEDICAL STATEMENT

Student's Name _____ DOB _____ School _____ County _____ WVEIS# _____

* Does this patient have a disability that affects her/his diet? Yes or No Diagnosis _____

* Does this patient have a non-disabling medical condition that affects his/her diet? Yes or No Diagnosis _____

Did you refer this patient's family to receive diet education? Yes or No

If yes, to whom: MD RN RD CDE Name _____ Phone _____

Diet Information sent to: School Nurse School Cook Child Nutrition Director Principal Other

PLEASE MARK ONLY THE AREAS THAT APPLY:

<p>Schools or sites may make substitutions for individuals with a non-disabling medical condition who are unable to consume the regular meal because of medical or other special dietary needs.</p> <p><input type="checkbox"/> FOOD ALLERGIES:</p> <ul style="list-style-type: none"> • _____ • _____ • _____ <p><input type="checkbox"/> SUBSTITUTIONS MUST BE LISTED</p> <ul style="list-style-type: none"> • _____ • _____ • _____ 	<p><input type="checkbox"/> CALORIC REQUIREMENTS: Please indicate the calories for each meal provided at school.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Daily Total</th> <th style="text-align: center;">Breakfast</th> <th style="text-align: center;">Lunch</th> <th style="text-align: center;">Snack</th> </tr> </thead> <tbody> <tr> <td style="text-align: left;">1200</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: left;">1500</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: left;">1800</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: left;">2000</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>	Daily Total	Breakfast	Lunch	Snack	1200	_____	_____	_____	1500	_____	_____	_____	1800	_____	_____	_____	2000	_____	_____	_____
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<p><input type="checkbox"/> SODIUM RESTRICTION (Specify Milligrams): _____</p> <p><input type="checkbox"/> CARBOHYDRATE COUNTING (Specify Grams): Breakfast _____ Lunch _____</p> <p><input type="checkbox"/> OTHER RESTRICTIONS:</p> <ul style="list-style-type: none"> • _____ • _____ • _____ 	<p><input type="checkbox"/> TEXTURE CONSISTENCIES for swallowing or chewing difficulties</p> <table style="width: 100%;"> <thead> <tr> <th style="text-align: left;">SOLIDS</th> <th style="text-align: left;">LIQUIDS</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Regular Chopped</td> <td><input type="checkbox"/> Regular Consistency</td> </tr> <tr> <td><input type="checkbox"/> Mechanical soft with ground meat</td> <td><input type="checkbox"/> Honey Consistency</td> </tr> <tr> <td><input type="checkbox"/> Mechanical soft with chopped meat</td> <td><input type="checkbox"/> Nectar Consistency</td> </tr> <tr> <td><input type="checkbox"/> Pureed</td> <td><input type="checkbox"/> Pudding Consistency</td> </tr> </tbody> </table>	SOLIDS	LIQUIDS	<input type="checkbox"/> Regular Chopped	<input type="checkbox"/> Regular Consistency	<input type="checkbox"/> Mechanical soft with ground meat	<input type="checkbox"/> Honey Consistency	<input type="checkbox"/> Mechanical soft with chopped meat	<input type="checkbox"/> Nectar Consistency	<input type="checkbox"/> Pureed	<input type="checkbox"/> Pudding Consistency										
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<p><input type="checkbox"/> NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE (for Breakfast and Lunch Only) Please specify amount and frequency of feeding</p> <p>Oral Feedings/Tube Feedings _____</p>																					

*Additional Comments: _____

Disability

- If an individual with a disability requires a special diet, the United States Department of Agriculture requires a medical statement form completed and signed by a licensed physician: medical doctor (MD) or doctor of osteopathic medicine (DO). An updated medical statement must be provided annually or when any change is prescribed.

Non-Disabled Medical Condition

- If an individual has a medical condition requiring a special diet and is medically certified, the school food service **may** make substitutions to the regular diet on a case by case basis. A medical statement is required and must be completed by a medical doctor (MD), doctor of osteopathic medicine (DO), physician's assistant (PA), or nurse practitioner (ANP) and include substitutions to the regular menu. An updated medical statement must be provided annually or when any change is prescribed.

* See Attached Definitions.

Sign Here:

Provider Name & Title (print) _____

Parent/Guardian Name (print) _____

Signature, Credentials _____ Date _____

Signature _____ Date _____

Provider Phone _____

Parent/Guardian Phone _____