Medical Statement for Children with Special Dietary

Special dietary request must be supported by a statement, which explains the food substitution that is requested. It must be signed by a recognized medical authority. The medical statement must include:

✓ an identification of the medical or other special dietary condition which restricts the child's diet;

✓ the food or foods to be omitted from the child's diet; and

✓ **the food or choice of foods to be substituted.**

Please completely fill out and return attached forms

Child Nutrition Program

Food Allergy/Disability Substitution Request

Student's Name: _____ Age: _____

School: _____ Grade: _____

Disability: _____ Allergy: _____

Food Allergy

Please indicate your child's special needs below:

☐ Diabetic* ☐ Lactose Free ☐ Peanut Allergy ☐ Other: _____

*** FOR DIABETIC ONLY: Menu selections must be made on the school calendar menu per Doctor's orders/individual health plan.**

FOR USE BY PHYSICIAN ONLY

Non Allowable Food	may be substituted with	Allowable Food(s)*
_____		_____
_____		_____
_____		_____
_____		_____

I certify that the above named student needs to be offered food substitutes as described above because of the student's medical allergy or disability indicated above. (Use back of form if needed.)

_____ _____

Name of Physician Telephone Number

_____ _____

Signature of Physician **(Required)** Date

I understand that if my child's medical or health need change, it is my responsibility to notify the school office.

_____ _____

Signature of Parent/Guardian Date

***NOTE: The Child Nutrition Department will attempt to accommodate the substitutions as requested but reserves the right to modify the menu based on product availability.**

Copies to: ☐ **Nurse** ☐ **Child Nutrition Office** ☐ **Campus File**

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER **Form provided courtesy of Food Allergy Research & Education (FARE) (www.foodallergy.org) 5/2013**

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To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**

   U.S. Department of Agriculture

   Office of the Assistant Secretary for Civil Rights

   1400 Independence Avenue, SW

   Washington, D.C. 20250-9410; or
2. **fax:**

   (833) 256-1665 or (202) 690-7442; or
3. **email:**

   program.intake@usda.gov

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