



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.

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:	<input type="checkbox"/> School Breakfast Program <input type="checkbox"/> National School Lunch Program <input type="checkbox"/> Afterschool Snack Program <input type="checkbox"/> Afterschool Supper Program <input type="checkbox"/> 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)? <input type="checkbox"/> YES <input type="checkbox"/> 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.					
Does the student already have a 504 Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO										
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 send completed form to The School Nurse OR Child Nutrition Dept. 35 Referendum Drive, Bolivia, NC 28422, Phone: 910-253-1098										

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?

Milk: Restrict All Forms Milk/Dairy

Egg: Restrict All Forms

Is this a Food Intolerance?

Milk: Restrict Fluid Milk Only - Cheese Allowed

Egg: Whole Only - Allowed as Ingredient

☐ YES ☐ NO☐ YES☐ YES☐ YES ☐ NO☐ YES☐ YES

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 ≤ ¼"
☐ Cut/Bite-Sized 1/4"-1/2"
☐ Finger Foods 1"-2"

☐ Other (please specify):

Designate safest consistency requirement for LIQUIDS:

- ☐ Nectar-thick ☐ Honey-thick
☐ Pudding-thick

☐ Other (please specify):

☐ Clear Liquid Time Frame: _____
☐ Full Liquid Time Frame: _____

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**)**NOTES:** (School Nutrition or other School Program staff)

School Nutrition Administrator's Signature:

Date:

IEP/504 Coordinator Signature:

Date: