CLEVELAND METROPOLITAN SCHOOL DISTRICT

MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY NEEDS

◆ **Please use black or blue ink only (NO PENCIL). Must complete all fields and return to School Nurse.** ◆

PART A: STUDENT INFORMATION

STUDENT FIRST NAME	STUDENT LAST NAME	DATE OF BIRTH	AGE

1. Does the child have a disability* as defined below. Please specify the major life activity affected by the disability in the space provided (i.e. eating, performing manual tasks, caring for one's self, walking, hearing, speaking, breathing, and/or learning). **If yes, complete Part B of this form and have it signed by a Licensed Physician.**	**Yes** ☐	**No** ☐
2. If the child is not disabled, does the child have special nutritional or feeding needs? If yes, complete Part B of this form and have it signed by a recognized Medical Authority.	**Yes** ☐	**No** ☐

PART B: SPECIAL DIETARY NEEDS

Diagnosis/Special Dietary Needs-Note:
Severe/LIFE THREATENING food allergies (Anaphylaxis) require a signature by a Licensed Physician.

Foods To Be Avoided:

Medical Restrictions - Food Allergies OR Food Intolerances. Please check all that apply

☐ Milk or Dairy	☐ Lactose Intolerant/Lactose-free Milk	☐ Wheat/Gluten
☐ Peanuts or Peanut Butter	☐ Soy	☐ Fish
☐ Tree Nuts	☐ Eggs	☐ Shellfish
☐ Other (please specify): _____		

Food to be Substituted (Acceptable Alternatives):

Texture Modification: Please check one (if applicable)

☐ Chopped (bite-size) ☐ Ground ☐ Blended ☐ Pureed

Physician/Medical Authority Printed Name	*Signature*	*Phone Number*	*Date*
		___ - ___ - ___	
Parent/Guardian Printed Name	*Signature*	*Phone Number*	*Date*
		___ - ___ - ___	

☐	**YES**	Parent/Guardian accepts accommodations offered and his/her child will be participating in the Child Nutrition Program and any other program offered within the child's school. ☐ Breakfast ☐ Lunch ☐ Snack ☐ Dinner
☐	**NO**	Parent/Guardian declines accommodations offered and his/her child will not be participating in the Child Nutrition Program and any other program offered within the child's school.

Parent/Guardian Signature _____ *Date* _____

* Under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. The definition included children with severe food allergies. The term child with a "disability" under Part B of the Individuals with Disabilities Education Act (IDEA) means a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who by reason thereof, needs special education and related services.

ANNUAL UPDATE. Order is good for one year from date of Licensed Physician or Medical Authority's Signature or School year.

Physician's Statement for Children with Disabilities and Special Dietary Needs

USDA regulations 7CFR Part 15b require substitutions or special dietary accommodations in school meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions in foods when that need is supported by a statement from a licensed physician. The physician's statement must identify:

- Child's Disability
- Major life activity affected by the disability
- Food or foods to be omitted from the child's diet
- Food or foods that must be substituted

The **CMSD MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY NEEDS** form is adapted from the USDA guidance: Accommodating Children with Special Needs: Guidance for School Food Service Staff, and may be used to obtain the required information from the physician and/or medical authority (see reference below)

Managing Severe/Life Threatening Food Allergies with Anaphylactic Reactions

The school food service authority is not required to make food substitutions for children with non-severe food allergies and food intolerances, who do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA.

The school food service authority may choose to make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Determinations are made on a case-by-case basis. This provision covers those children who have food intolerances or allergies but do not have life-threatening reactions. In this case, A Medical Authority (licensed physician, physician's assistant, registered nurse, nurse practitioner or registered dietitian) can complete and sign the **CMSD MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL DIETARY NEEDS.** The completed and signed form must be sent to the School Nurse.

Other Special Dietary Needs (Religious Restrictions)

If there is no known allergy, food intolerance or disability, but the parents request that a specific food be eliminated for religious reasons, the school food service authority may choose, at their discretion, to make a food substitution, but is not required to provide a substitution. In this case, the parent shall obtain Request for Meal Substitution for Religious Reasons form from the school food service manager, complete, sign and return the form to the food service manager at the school.

* References: Accommodating Children with Special Needs: Guidance for School Food Service Staff, United States Department of Food and Nutrition Service, Fall 2001 http://www.fns.usda.gov/cnd/Guidance/default.htm

CLEVELAND METROPOLITAN SCHOOL DISTRICT

SPECIAL MEALS PRESCRIPTION FORM

◆ **Please use black or blue ink only (NO PENCIL). Must complete all fields and return to School Nurse.** ◆

Student Name: _____ Student ID: _____

School Name: _____ DOB: _____

Disability: ☐ Disabled (Federal Policy: as determined by physician) ☐ Non-disabled (school district policy)

Disability or medical condition:

☐ Food Allergy	☐ Food Intolerance	☐ Celiac Disease	☐ Tube Feeding
☐ Diabetes	☐ Cerebral Palsy	☐ Cystic Fibrosis	☐ Spina Bifida
☐ Autism/PDD	☐ Failure to Thrive	☐ Down Syndrome	☐ PKU
☐ Galactosemia	☐ None		
☐ Kidney/Renal Disease	☐ Other _____		

Description of Condition Requiring Special Diet: _____

Special Diet: *(Check all that apply)* ☐ Diabetes ☐ Reduced Calorie ☐ Increased Calorie ☐ Modified Texture

Date Effective: From: _____ To: _____

PHYSICIAN/MEDICAL AUTHORITY SIGNATURE SECTION	
☐	I certify that the above named student needs special meals prepared as described above because of the student's disability.
☐	I certify that the above named student would benefit from special meals as described above, however this child is not disabled. It is up to the discretion of Food and Child Nutrition Services if and for what conditions they will provide substitutions.

_____ ___ - ___ - ___ _____

Physician/Medical Authority's Printed Name *Office Phone Number* *Date*

_____

Physician/Medical Authority's Signature

Physician's/Medical Authority Stamp → *** Stamp must be present*	

FCNS OFFICE USE ONLY

Reviewed By: _____ Approved By: _____

CC:

☐ Parent/Guardian	☐ Special Education	☐ School Principal	☐ Physician
☐ Executive Director FCNS	☐ School Nurse	☐ Cafeteria	☐ Nutritionist
☐ Central Kitchen Facility	☐ Other _____		