# Guidance for Completing the Medical Statement for Students with Unique Mealtime Needs for School Meals

## PART A - PARENT/GUARDIAN

The *Medical Statement for Students with Unique Mealtime Needs for School Meals* helps schools provide meal modifications for students who require them. Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare providers. Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals and snacks to your child while at school.

Your participation in this process is very important. The sooner you provide this signed and completed form to your child's school, the sooner the School Nutrition Program and their staff can prepare the food your child needs. Your signature is required for your school to take action on the Medical Statement.

### Follow these steps to get started:

1) Complete all sections of PART A of the Medical Statement.
2) Take the Medical Statement to your child's pediatrician or family doctor/nurse practitioner/physician's assistant and have him/her complete PART B.
3) RETURN THE FULLY COMPLETED MEDICAL STATEMENT WITH SIGNATURES FROM BOTH PARENT/GUARDIAN AND MEDICAL AUTHORITY, TO YOUR CHILD'S TEACHER, PRINCIPAL, NURSE, SPECIAL EDUCATION CASE MANAGER, OR SECTION 504 CASE MANAGER, SCHOOL NUTRITION ADMINISTRATOR, OR THE SCHOOL STAFF PERSON WHO GAVE YOU THE BLANK FORM.
4) Ask the school when a team, including you, the school system's School Nutrition Administrator and others, will meet to consider the information provided on the form. You may also invite people from the community who are knowledgeable about your child's feeding and nutrition issues to the meeting. These would be people who could help school staff design a school mealtime plan for your child, like your child's pediatrician, nurse speech-language pathologist, occupational therapist, registered dietitian or personal care aide.

## PART B – RECOGNIZED MEDICAL AUTHORITIES *(Licensed physician, physician assistant, and nurse practitioner)*

A Recognized Medical Authority's signature is *required* for students with a disability. Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare providers. Meal modifications are implemented based on medical assessment and treatment planning and *must be ordered by a recognized medical authority.*

Please consider the following as you complete **PART B** of the Medical Statement:

1) Complete all sections of **PART B**. Completion of all items will streamline efficient care of the student at school.
2) Be as specific as possible about the nature of the student's physical or mental impairment, its impact on the student's diet and major life activities that are affected. In the case of food allergy, please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).
3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications, or other dietary restrictions, please refer the child/family to the appropriate health care professional for completion of the assessment. Schools do not routinely have instrumentation and/or staff trained for a comprehensive nutrition and feeding assessment and must partner with community providers to meet a student's unique feeding and nutrition needs.
4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to the school.
5) Consider being available to consult with the student's mealtime planning team as it implements the feeding/nutrition care plan.

## PART C – SCHOOL NUTRITION ADMINISTRATOR and IEP/504 REPRESENTATIVE

Please consider the following as you complete **PART C** of the Medical Statement:

Signature of the School Nutrition Administrator and 504 Coordinator or IEP Case Manager/EC Program representative indicates the medical statement has been received, reviewed, and a plan to address the student's unique mealtime needs is being developed/implemented.

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# 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. See *"Guidance for Completing Medical Statement for Students with Unique Mealtime Needs for School Meals"* (previous page) for help in completing this form.

**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:** | ☐ **School Breakfast Program** ☐ **National School Lunch Program** ☐ **Afterschool Snack Program** ☐ **Afterschool Supper Program** ☐ **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)?**
☐ YES ☐ NO

**Does the student already have a 504 Plan?**
☐ YES ☐ 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.*

**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 return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's teacher, principal, nurse, Special Education case manager, or Section 504 case manager, School Nutrition Administrator, or the school staff person who gave you the blank form.***

**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
□ Learning □ Breathing □ Self-Care □ Eating/Digestion
□ Other *(please specify):*

**Is this a Food Allergy?** □ YES □ NO

**Is this a Food Intolerance?** □ YES □ NO

**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 □ Ground □ Chopped
□ Other *(please specify):*

**Designate safest consistency requirement for LIQUIDS:**

□ Clear Liquid □ Nectar-thick □ Full Liquid □ Honey-thick □ Pudding-thick
□ Other *(please specify):*

**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**)*

**School Nutrition Administrator's Signature:** **Date:**

**IEP/504 Coordinator Signature:** **Date:**

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