Medical Plan of Care for School Nutrition Program

For Students who require Special Dietary Accommodations

Page 1 is to be completed by a Parent/Guardian. Page 2 is to be completed by a licensed physician/physician assistant/nurse practitioner/registered dietitian.

Please return completed forms to the School Nutrition Manager or email to keshia.williams@haralson.k12.ga.us.

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7 CFR Part 15B require substitutions or modifications in school nutrition program meals for children whose disability restricts their diet. The purpose of this form is for your licensed physician/physician assistant/nurse practitioner to document this disability.
- Under the Americans with Disabilities Act, any condition that substantially limits a major life activity constitutes a disability; included but not limited to special dietary needs for food allergens.
- Haralson County School Nutrition Program provides information based on label information provided to us and cannot guarantee that food products served are not processed in plants that also process nuts or other allergens.
- Labeled foods will only note the presence of nine major allergens: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, soybeans and sesame. **While efforts will be made to avoid other allergens, the Haralson County School District cannot guarantee that labels will disclose all possible allergens.**
- If you have specific questions, please contact the School Nutrition Department.

Part 1: To be completed by Parent/Guardian

Child's Name:	Date of Birth:	Gender: M F
Name of School:	Grade Level/Classroom:	
Parent's/Guardian's Name:	Address, City, State, Zip Code:	
Phone: / Email Address:		

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ **(medical authority)** to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to the Haralson County School District and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ **(date)**. This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent/guardian, or official representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature: _____ Date: _____

(Signing this section is optional, but may prevent delays in allowing us to speak with the physician)

Part 2: Parent Signature:	Date:

Part 3: Disability/Special Dietary Needs (To be completed by Physician/Physician Assistant/Nurse Practitioner)

Does the child have a **disability/special dietary need?** Yes ☐ No ☐

If Yes,

Please identify the disability/special dietary need, describe the major life activity or activities affected by the disability/special dietary need:

Does the child's disability/special dietary need affect their nutritional or feeding needs? Yes ☐ No ☐

If the child has a disability/special dietary need that requires a special dietary/feeding need, please have a licensed physician complete Part 4 of this form.

Part 4: Diet Order (To be completed by Physician/Physician Assistant/Nurse Practitioner/Registered Dietitian)

List any dietary restrictions **required** as a result of the student's disability/special dietary need (list specific foods to be omitted):

NOTE: Labeled foods will only note the presence of nine major allergens: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, soybeans and sesame. While efforts will be made to avoid other allergens, the Haralson County School District cannot guarantee that labels will disclose all possible allergens.

List specific foods to be substituted (substitutions cannot be made unless section is completed):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

Indicate any other comments about the child's eating or feeding patterns:

Physician/Physician Assistant/Nurse Practitioner/Registered Dietitian Name (Printed):	Office Address and Phone Number:
Physician/Physician Assistant/Nurse Practitioner/Registered Dietitian Name (Signature):	Date:

Please send this document to the School Nutrition Manager or email to keshia.williams@haralson.k12.ga.us

A copy of this form should be kept by the School Nutrition Manager and the School Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school nutrition services.