BESSEMER BOARD OF EDUCATION
CHILD NUTRITION PROGRAM
1621 5TH AVENUE NORTH
BESSEMER, AL 35020
(205)432-3008 FAX (205)432-3065

Parent/Guardian information Letter
"Diet Prescription for Meals at School 2023-2024" Form

Due to the USDA (United States Department of Agriculture) regulations, Bessemer City Schools **cannot replace or make any diet substitutions** unless we have a "Diet Prescription for Meals at School" form completed by your Licensed Physician/Recognized Medical Authority. This includes, but is not limited to making substitutions for milk intolerances. **A licensed physician is required to fill out the "Diet Prescription for Meals at School" form if the allergy is life-threatening. Any recognized medical authority may fill out the form for all other food allergies or intolerances. Each form is valid only for current school year.**

TO PROCESS THE FORM PLEASE FOLLOW THESE STEPS

- Please review the "Diet Prescription for Meals at School" form
- Give the form to your licensed Physician/Recognized Medical Authority to complete
- Return the complete form to the School Nurse and or Cafeteria Manager

Understand that if your child's medical or health needs change at any time, it is your responsibility to notify the School Nurse **and complete a new "Diet Prescription for Meals at School" form with your licensed Physician/ Recognized Medical Authority.** Again, each form is only valid for the current school year.

Definition of Recognized Medical Authority
In Alabama, a recognized medical authority is defined as one of the following health professionals: doctor (licensed physician), physician assistant, nurse practitioner, registered nurse and registered dietitian.

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DIET PRESCR1TTION FOR MEALS AT SCHOOL FORM FOR SCHOOL NURSE AND CAFETERIA MANAGER:

Name of Student: ______________________________ D.O.B. ________________ ID#__________

School: ________________________ Grade: ____________ Teacher: ____________________________

USDA Regulations & Guidance: A child with disability must have licensed Physician's statement that includes:

- **The child's disability**
- **An explanation of why the disability restricts the child's diet**
- **The major life activity affected by the disability**
- **The food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.**

NOTE TO PARENT'S/GUARDIANS: The district requires that all students *who* need a special meal for breakfast or Lunch must do the following:

1. **Present this form signed by parent or legal guardian and by physician/recognized medical authority (US. only).**
2. **Keep the diet prescription current by submitting a new form at the beginning of each school year.**
3. **To change a diet order, please complete and return a new form signed by a parent or legal guardian and by the physician/recognized medical authority.**

Information below to be completed by RECOGNIZED MEDICAL AUTHORITY:
Breakfast meal needed: (circle one) YES or NO Lunch meal needed: (circle one) **YES or NO**
List medical conditions or diagnoses for special diet:

Therapeutic Diet Prescription: (check all that apply)

- **Diabetic (Type 1_________ Calories; Type 2__________ Calories)**

____

- **Increased calories Reduced Calories (low fat, low cholesterol, low simply Carbohydrate):**

____

- **High Fiber** _________
- **Peptic Ulcer Disease** _________
- **Lactose Intolerance** _________
- **Food Allergies** _________
- Other:____
- (Specify____

HT:_______ WT: __________ BMI (if available):_________

Mechanically Altered. Denote texture allowed:

________Regular _________Soft _________Chopped __________Ground _________Pureed

Other information/instructions **regarding the diet or feeding**

FOODS OMITTED (Please check food groups to be omitted)

- **Meat/Meat Alternates**
- **Bread/Cereal Products**
- **Fruits/Vegetables**
- **Milk/Milk Products (currently serving 1% and and Low-fat)**
- **Other (Describe) ____**

(Please provided suggested substitutions for omitted foods or attach information)

USDA Regulations & Guidance: A child with medical conditions that are NOT disabilities must have licensed Physician's statement that includes:

- **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.**

Is parent allowed to discontinue diet order without written physician consent? YES Or NO
If yes, parent must notify the Child Nutrition Program in writing with the intent to discontinue.

Diet Expiration Date:____

Signature : ____
Physician/recognized Medical Authority Physician /Recognized Medical Authority

Date: __________________________

Physician Address____

Phone: ________________________________ **Fax:** ________________________________

FOR PARENTS/GUARDIANS

By signing below, I ____ **, parent of**
PRINTED NAME

____ **Authorize the Child Nutrition Program**
STUDENT PRINTED NAME

personnel to serve my child the diet recommended by the physician/recognized medical authority.

Parent(s)/Guardians Signature ____

Original — Cafeteria Manager ______________________________________ **Date** _________

Copy — School Nurse _________________________ **Date** _____________________

Central Office_________________________ **Date** _____________________

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This institution is an equal opportunity provider.

FOR PARENTS/GUARDIANS

By signing below, I ____ , parent of
PRINTED NAME

____ Authorize the Child Nutrition Program
STUDENT PRINTED NAME

personnel to serve my child the diet recommended by the physician/recognized medical authority.

Parent(s)/Guardians Signature ____

Original — Cafeteria Manager _____________________________________ Date _________

Copy — School Nurse _________________________ Date _____________________

Central Office _________________________ Date _____________________

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