

Sumter County Schools Medical Plan of Care for School Nutrition Program, SY 2026 (Students with Disabilities and Non-Disabling Special Dietary Needs)

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

- USDA regulations 7CFR Part 15B require substitutions or modifications in school nutrition program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."
- The school food authority may choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).
- The school food authority may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. If available, this will be indicated in Part 2. A parent/guardian or **recognized medical authority** (physician, physician assistant, or nurse practitioner) may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Child's Name		Date of Birth	M	F
Name of School/Center/Program		Grade Level/Classroom		
Parent's/Guardian's Name		Address, City, State, Zip Code		
()	()			
Home Phone	Work Phone			

Part 2: Request for milk substitution for non-disabling special dietary needs only

☐ School/school district does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2. Water is available for all students.

☐ School/school district provides **Lactose – Free Milk** as a milk substitute to students with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district. Water is available for all students.

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk? Yes ☐ No ☐
List medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):

Medical Authority or Parent/Guardian Signature: _____ Date: _____

Part 3: To be completed by Physician/Medical Authority

Disability/Special Dietary Needs

Does the child have a **disability**? Yes ☐ No ☐

If Yes,

Please identify the disability and describe the major life activities affected by the disability.

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

If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes ☐ No ☐

(*These accommodations are optional for schools to make)

If Yes, please identify the medical or other special dietary condition which restricts the diet.

If the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 4: To be completed by Physician/Medical Authority

Diet Order

List any dietary restrictions, such as food allergies or intolerances (list specific foods to be omitted):

List specific foods to be substituted (substitution 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:

List any special equipment or utensils needed:

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

Physician/Medical Authority Printed Name and Office Phone Number

Address or Office Stamp

Physician/Medical Authority's Signature

Date

Part 5: Parent Signature

Date

Part 6: School Nutrition Program Director Signature

Date

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 _____ (school/program) 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 by allowing us to speak with the physician)

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent confirmed no change in diet order. ____ Date ____ ____ Date ____ ____ Date ____

Special Dietary Needs

This institution is an equal opportunity provider.

____ Date _____ ____ Date _____ ____ Date _____ ____ Date _____ ____ Date _____

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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

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05/05/2022