SASD Medical Plan of Care for School Food Service Form Instructions

Summary

- ◆ Parents/Guardians requesting a milk substitution in a school lunch should complete Part 1 and Part 2. (Note: Lactaid or soy milk are the only permitted substitutes)
- Parents/Guardians requesting specific foods for special dietary needs or substitutions due to a disability should complete Part 1 and Part 5, and have a physician or recognized medical authority (physician, physician assistant or nurse practitoner) complete Part 3 and Part 4.

Part 1 Completed by Parent/Guardian for all requests for special dietary needs

- All parent's/guardians with a student with special dietary needs should complete **Part 1**.

Part 2 Requests for <u>milk substitution</u> for non-disabling special dietary needs <u>ONLY</u>

- If a student does not have a **disabling** special dietary need, parent's/guardians should complete **Part 2** and return the form to the school nurse.
 - ◆ Can be completed by a parent/guardian <u>OR</u> a recognized medical authority (physician, physician assistant or nurse practitioner).
 - Only for requesting a milk substitute in the school lunch. The only fluid milk substitute offered for a non-disabling dietary need is lactaid or soy milk.

Part 3 Statement of Disability - To be completed by Physician/Medical Authority

- Must be completed by a Physician or Recognized Medical Authority.
- This section declares that student has a medical disability that affects the students nutritional needs.

Only a physician or recognized medical authority can classify a student's dietary need(s) as disabling.

Part 4 Diet Order - To be completed by Physician/Medical Authority

- Must be completed by a Physician or Recognized Medical Authority.
- Lists all foods that substitutes must be provided for as well as what specifically must be substituted and in what form.

Part 5 Parent or Guardian Signature

- Any parent/guardian that has had a physician or recognized medical authority complete Parts 3 and 4 must sign in this section.

Health Insurance Portability and Accountability Act Waiver

Please read this waiver and sign as appropriate. Signing is optional but may prevent delays by allowing the school nurse or Food Service Director to speak directly with the physician regarding your child's special diet needs.

Return the completed form (as applicable) to the school nurse.

The school nurse will forward a copy to the Food Service Director to accommodate special dietary needs.

Shippensburg Area School District

Medical Plan of Care for School Food Service

(Students with Disabilities and Non-Disabling Special Dietary Needs)

The following child is a participant in the National School Lunch program.

- ◆ USDA regulations 7CFR Part 15B require substitutions or modifications in NSLP 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."
- SASD has chosen to accommodate students with non-disabling special dietary needs that are supported by a signed statement by a parent/guardian or recognized medical authority (physician, physician assistant or nurse practitioner).
- ◆ The school food authority will make milk substitutions available for students with a non-disabling special dietary need, such as milk intolerance. These substitutions will/must meet nutrient standards identified in regulations. This information is indicated in Part 2. A parent/guardian or recognized medical authority may complete Part 1 and Part 2. If fluid milk is the only substitution being requested, complete Parts 1 and 2 only.

		sted, complete raits 1 and 2 only.				
Part 1	Completed by Parent/Guar	ardian for all requests for special dietary needs				
Childs Name		Child's Date of Birth	M F			
School child attends		Grade/Classroom	•			
Parent's/Guardians Name		Address, Town, Zip				
()	[()	1				
Home Phone	Work Phone	1				
Part 2		ion for non-disabling special dietary needs <u>ONLY</u>				
	•	r Soy Milk as a milk substitute to students with non-disa ted by a recognized Medical Authority.	bling special			
Yes	No	Il dietary need that restricts intake of fluid milk?				
		requires substitution (lastaid or sou mills) coloctions				
List the medical of s	врестат спетагу пеес апо ттагк арр	propriate substitution (lactaid or soy milk) selection:				
l						
Lactaid (for m	ilk sugar intolerance)	Soy Milk (for milk protein intolerance)				
Parent/Guardian o	r Medical Authority Signature:	Date:				
•						
Part 3	Statement of Disability -	To be completed by Physician/Medical Authority				
Does the child have	a disability? Yes	No \square				
	describe the major life activities a					
, ,	,	•				
l						
6						
	oility affect their nutritional or fee					
	t have a disability, does the child I ng needs (non-inclusive of fluid mi					
		g need, a physician/recognized medical authority must				
		ry must also sign and stamp with the office name & add	aress.			
Part 4		mpleted by Physician/Medical Authority				
List any dietary rest	rictions, such as disabling food all	lergies, intolerances or restrictions:				
1						
List SPECIFIC foods	to be substituted (Substitution car	nnot be made unless section is completed):				
	to be substituted (Substitution car	mot be made amess section is completedy.				
1						

continued next page

Part 4 - continued								
List foods that need th	e following change in texture.	If all foods need to be prep	ared in this manner, indi	cate "All."				
Cut up/chopped into b	ite sized pieces:							
Finely Ground:								
Pureed:								
List any special equipn	nent or utensils needed:							
Indicate any other comments about the child's eating or feeding pattern:								
·								
Physician's Name and	Office Phone Number	Office Stamp						
Physician/Medical Au	therity's Signature	Date						
Priysician/ivieuicai Au	thority's Signature	Date						
- · -	2							
Part 5	Ра	rent or Guardian Signatu	ire					
	Signature	_	Date					
	Signature	ļ	Date	<u>.</u>				
Health Insurance Po	ortability and Accountabilit	v Act Waiver						
In accordance with th Educational Rights an protected health information listed I understand that I mafor my child. I understand has alreading the information has alreading to the information has alreading the second se	e provisions of the Health Insu d Privacy Act, I hereby authori rmation of my child as is neces hool District Food Services and on this form and in their reco ay refuse to sign this authoriza and that permission to release dy been released. My permissi eleased for the specific purpos	rance Portability and Accounter sary for the specific purpos I I consent to allow the phy rds concerning my child wit tion without impact on the ethis information may be re on to release this informati	(medical authorite of Special Diet informat sician/medical authority the school program as religibility of my request fescinded at any time excession will expire on	cy) to release such ion to co freely exchange necessary. or a special diet pt when the				
	fies that he/she is the parent, y to sign on behalf of that pers		of the person listed on th	is document and				
Parent/Guardian Sign	nature:		Date:					
	Area hala	w for SASD Office Use or	alv					
			пу					
	Scr	nool Nurse Signature						
	Nursa signatura	_	Date					
It is recommended that	Nurse signature It parent's/guardian's review for a new form signed by the Physical			red. Any changes				
Parent confirmed no c		Date	Date	Date				
Date	Date	Date	Date	Date				

School Nurses and the Food Service Department should keep copy of this form. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service.