SPECIAL DIETARY NEEDS MEDICAL STATEMENT

Student's Name_____DOB_____School_____County_____WVEIS#_____

* Does this patient have a disability that affects her/his diet? Yes or No Diagnosis _____

*Does this patient have a non-disabling medical condition that affects his/her diet? Yes or No Diagnosis _____

Did you refer this patient's family to receive diet education? Yes or No

If yes, to whom: ☐MD ☐ RN ☐ RD ☐ CDE Name_____ Phone _____

Diet Information sent to: ☐School Nurse ☐ School Cook ☐Child Nutrition Director ☐Principal ☐Other

Please mark only the areas that apply:

Schools or sites may make substitutions for individuals with a non-disabling medical condition who are unable to consume the regular meal because of medical or other special dietary needs.

☐ FOOD ALLERGIES:

- _____
- _____
- _____

☐ SUBSTITUTIONS MUST BE LISTED

- _____
- _____
- _____

☐ CALORIC REQUIREMENTS: Please indicate the calories for each meal provided at school.

Daily Total	Breakfast	Lunch	Snack
1200	_____	_____	_____
1500	_____	_____	_____
1800	_____	_____	_____
2000	_____	_____	_____

☐ SODIUM RESTRICTION (Specify Milligrams):_____

☐ CARBOHYDRATE COUNTING (Specify Grams):

Breakfast _____ Lunch _____

☐ OTHER RESTRICTIONS:

- _____
- _____
- _____

☐ TEXTURE CONSISTENCIES for swallowing or chewing difficulties

SOLIDS	LIQUIDS
☐ Regular Chopped	☐ Regular Consistency
☐ Mechanical soft with ground meat	☐ Honey Consistency
☐ Mechanical soft with chopped meat	☐ Nectar Consistency
☐ Pureed	☐ Pudding Consistency

☐ NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE
(for Breakfast and Lunch Only)
Oral Feedings/Tube Feedings_____

Please specify amount and frequency of feeding
_____

*Additional Comments:_____

Disability

•If an individual with a disability requires a special diet, the United States Department of Agriculture requires a medical statement form completed and signed by a licensed physician: medical doctor (MD) or doctor of osteopathic medicine (DO). An updated medical statement must be provided annually or when any change is prescribed.

Non-Disabled Medical Condition

•If an individual has a medical condition requiring a special diet and is medically certified, the school food service **may** make substitutions to the regular diet on a case by case basis. A medical statement is required and must be completed by a medical doctor (MD), doctor of osteopathic medicine (DO), physician's assistant (PA), or nurse practitioner (ANP) and include substitutions to the regular menu. An updated medical statement must be provided annually or when any change is prescribed.

* **See Attached Definitions.**

Sign Here:

_____ Provider Name & Title (print)

_____ Signature, Credentials Date

_____ Provider Phone

_____ Parent/Guardian Name (print)

_____ Signature Date

_____ Parent/Guardian Phone