New Albany-Floyd County Consolidated School Corporation School Health Services
2016-2017 School Year

Medical Referral for Special/Modified School Meals/Food Allergies

To be completed by prescribing Health Care Provider

This form is intended to meet current federal regulations found in USDA FNS Instruction 783-2, Revision 2, Meal Substitutions for Medical or Other Special Dietary Reasons.

Section A **TO BE COMPLETED BY PARENT (please print or type)**

Student name____Date of birth____

School______________________________________Grade__________________Teacher____

Parent/Guardian name________________________________Daytime phone no.____________________________Permission for school nurse

to communicate with physician regarding this request____/_______________

Parent's signature Date

Section B **TO BE COMPLETED BY PHYSICIAN (please print or type)**

Describe the patient's condition/disability that necessitates dietary modification: _____________________________________

____

Check the major life activities affected by condition/disability listed above: ❑eating ❑self-care ❑ manual tasks ❑walking ❑seeing ❑speaking ❑sitting ❑thinking ❑learning ❑breathing ❑concentrating ❑interacting with others ❑working ❑reading ❑standing ❑lifting ❑bending ❑Other: ____

Special/Modified Diet Prescription (*Check all that apply*):

❑ Specific Calories: ❑Amount of_____________breakfast calories ❑Amount of ___________lunch calories
❑ Modified Texture: ❑ regular ❑ chopped ❑ ground ❑ pureed (***Please check which texture***)
❑ Sodium Restriction: ❑ Amount________________ or ❑ No Added Salt
❑ Tube Feeding: Formula Name__________________________ Amount_________________ Time(s) to be given ______________
Administer via: ☐ Pump Flow Rate _____ cc/hr ☐ Gravity ☐ Other: _____________________________
Amount of water to follow feeding: _________ cc
Oral Feeding: ❑ No ❑ Yes If Yes, specify foods ____

Note: If G-tube becomes dislodged, parent, trained emergency contact, or EMS will be called to replace. School personnel cannot insert g-tubes.

❑ Other (Describe)____

Foods Omitted and Substitutions:
Specific foods or food group to be omitted____

Food substitutions____

Food allergies (specify)____

Does the food allergy result in severe, life threatening reaction? ❑ yes ❑ no

Describe the allergic reaction____

Does student require medication for allergic reactions? ❑ yes* ❑ no

***If medication required* for the condition, please complete appropriate medication or action plan form.**

I certify the above named student needs special school meals prepared as described above because of the student's disability or chronic medical condition.

______________________	______________________	____________________	__________
Physician's name printed	**Physician's signature**	**Physician's telephone no.**	**Date**

Distribution List/Date Given: ☐School Nurse ___________, ☐Food Services ___________, ☐Teacher ____________

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR