

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