New Albany-Floyd County Consolidated School Corporation School Health Services
2020-2021 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: _____________breakfast calories ❑Amount: ___________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

<u>If medication required</u> 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 ___________

<u>THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR</u>