New Albany/Floyd County Consolidated School Corporation

MEDICAL REFERRAL FOR SPECIAL/MODIFIED SCHOOL MEALS/FOOD ALLERGIES

Current Federal Regulations require that requests for Special/Modified Meals be authorized by a licensed physician (USDA FCS Instruction 783-2, Revision 2, Meal Substitutions for Medical or Other Special Dietary Reasons.) For each student requesting Special/Modified Meals, a copy of this form is to be completed and maintained with the student's health records at school. If the student does NOT require Special/Modified Meals, please dispose of this form.

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

Student name_____Date of birth_____

Student address_____Phone no._____

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)**

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
- ❑ Diabetic
- ❑ Other (Describe)_____

Foods Omitted and Substitutions (Check food groups or specific foods to be omitted and suggest substitutions.)

- ❑ meat and meat alternates ❑ milk and milk products
- ❑ bread and cereal products ❑ fruits and vegetables

Specific foods to be omitted_____

Food substitutions_____

_____

Other information regarding diet or feeding_____

_____

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

Medication, dosage and time to be given:_____

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: School Nurse, Food Services, Teacher

5/2002, 1/2006