UCPS
UNION COUNTY PUBLIC SCHOOLS

407 North Main Street
Monroe, NC 28112
704-296-3000
704-296-0004
ucps.k12.nc.us

School Nutrition Services

Dear Parents/Guardians:

Union County Public Schools is committed to serving your child nutritious meals each day. We recognize that some students have special dietary needs due to a medical reason, such as allergy, intolerance or therapeutic diet. In order for the UCPS School Nutrition Department to meet special dietary needs that students may have, we need for you to complete a Diet Order form. This Diet Order form will remain on file in the health record of the student and on file in the cafeteria computer system. This diet order should include all important information for the student and must be updated periodically (as the student's condition changes or every three years). Therefore, we need a completed Diet Order from your child's physician/health care provider indicating your child's dietary needs, allergies or food substitutions. We are certain that your child's physician/health care provider will cooperate in helping you get this needed information to document your child's health and nutrition needs.

Attached please find the Diet Order form which requires contact information and signature of both parent/guardian and recognized medical authority. This form needs to be completed and returned to your school's cafeteria manager or the School Nutrition office for our records at least two weeks before the first day of school. The school cafeteria will record information in the cafeteria computer system to monitor student meal items and trigger special instructions sent to the cafeteria manager. This information is very important to maintain in the computer files because it will alert cafeteria staff of special dietary needs or food substitutions that you and your child's physician have indicated are required. There will be a delay between our receipt of the information and the time it takes to prepare the cafeteria. You will receive a letter once the cafeteria is able to provide your student an appropriate meal.

Please remember, if your child requires any special accommodations for food substitutions, this information should be noted on the diet order form. Please record information only if there are specific directions from the ordering physician. If there are other food choices on the menu that are not allergens, then your child will be expected to choose from those foods rather than have substitutions made. Food preferences are not taken into consideration with regard to available foods, just as this is not a consideration for a child without food allergies.

Should you have questions or concerns, please feel free to call the School Nutrition office at 704.296.3000, Ext. 2071. Contact School Nutrition office if Spanish Diet Order is needed.

UCPS School Nutrition Services
407 N. Main St. Suite 100, Monroe, NC 28112

Guidance for Completing the Medical Statement for Students with Special Nutritional Needs for School Meals

PART A – PARENT/GUARDIAN

The *Medical Statement for Students with Special Nutritional Needs for School Meals* helps schools provide meal modifications for students who require them. Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals to your child while at school.

Your participation in this process is very important. The sooner you provide this signed and completed form to your child's school, the sooner the School Nutrition Program or school staff can prepare the food your child requires. Your signature is required for your school to take action on the medical statement. The school staff cannot change food textures, make food substitutions, or alter your child's diet at school without all the information filled in on this form.

Please follow the steps below to get started:

1) Complete all items of **PART A** of the Medical Statement.
2) Take the Medical Statement to your child's pediatrician or family doctor and have him/her complete PART B.
3) Return the properly signed Medical Statement to your child's teacher, principal, nurse, Special Education case manager, or Section 504 case manager, School Nutrition Administrator, or the school staff person who gave you the blank form.
4) Ask the school when a team, including you and the school system's School Nutrition Administrator, will meet to consider the information provided on the form. You may invite people from the community who are knowledgeable about your child's feeding and nutrition issues to the meeting. These would be people who could help school staff design a school mealtime plan for your child, like your child's pediatrician, nurse, speech-language pathologist, occupational therapist, registered dietitian or personal care aide.

PART B – RECOGNIZED MEDICAL AUTHORITIES *(Licensed Physician, Physician Assistant, and Nurse Practitioner)*

This form helps schools provide meal modifications for students who require them. Completion of all items will streamline efficient care of the student.

The school cannot change food textures, make food substitutions, or alter a student's diet at school without a proper statement from you. Meal modifications are implemented based on medical assessment and treatment planning and must be ordered by a recognized medical authority.

Please consider the following as you complete PART B of the Medical Statement:

1) Complete all items of **PART B.** Completion of all items will streamline efficient care of the student at school.
2) Be as specific as possible about the nature of the student's physical or mental impairment, its impact on the student's diet and major life activities that are affected. In the case of food allergy, please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).
3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications, or other dietary restrictions, please refer the child/family to the appropriate healthcare professional. Schools do not routinely have instrumentation and/or staff trained for a comprehensive nutrition and feeding assessment and must partner with community providers to meet a student's special feeding and nutrition needs.
4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to the school.
5) Consider being available to consult with the child's school team as it implements the feeding/nutrition care plan.

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Medical Statement for Students with Special Nutritional Needs for School Meals

Original to School Nutrition ☐ Copy to Teacher ☐ Copy to School Nurse ☐

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for reasonable meal accommodations at school. See "Guidance for Completing Medical Statement for Students with Special Nutritional Needs for School Meals" for form assistance.

Note: The entire document must be completed (Part A – by a parent/guardian; Part B – by a recognized medical authority) to be processed by the Union County Public Schools – School Nutrition Services Department.

PART A (To be completed by Parent/Guardian)

**Parent/guardian please fill and complete part A of this document in its entirety to be processed.*

Name of Student: (Last) _____ (First) _____ (Middle) ____

Date of Birth _____ Student ID # _____ School _____ Grade _____

Will student eat breakfast provided by the school cafeteria? ☐ Yes ☐ No

Will student eat lunch provided by the school cafeteria? ☐ Yes ☐ No

Will the student eat a snack provided by the After School Snack Program? ☐ Yes ☐ No

Printed Name of Parent/Guardian: _____

Mailing Address: _____ City: _____ State/Zip: _____

Phone number(s): _____ (Work) _____ (Home) _____ (Cell)

Email Address: _____

What concerns do you have about your student's nutritional needs and ability to safely participate in mealtime at school?

Does the student have an identified disability and an Individualized Education Program (IEP) or 504 Plan?

☐ Yes ☐ No

NOTE: Special dietary needs for students without an IEP or 504 Plan are accommodated at the discretion of the School Nutrition Services Administrator and policies of Union County Public Schools.

Parental/Guardian Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form.

Parent/Guardian Signature: _____ Date:_____

PART C (To be completed by School Nutrition Services)

School Nutrition Services Notes *(if needed - attach additional documents):*

SNS Signature: _____ **Date:** _____

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Patient/Student Name: _____

PART B (MUST be completed by Licensed Physician)

**Part B should ONLY be filled out by a recognized medical authority. This portion should NOT be filled out by the parent/guardian.*

Student Diagnosis or Condition:

☐ Food Allergy ☐ Food Intolerance

☐ Life Threatening Allergy (Check appropriate box(es) - ☐ Ingestion ☐ Contact ☐ Inhalation)
**Students with life threatening food allergies must have an emergency action plan in place at school.*

☐ Disability (*Specify*) _____ Major life activities affected _____

☐ Other (*Specify*) _____

Designate texture modifications for FOOD:

☐ Pureed ☐ Chopped
☐ Ground ☐ No Change Needed
☐ Mechanical Soft ☐ Other *(please specify)* _____

Designate consistency modifications for LIQUIDS:

☐ Clear Liquid ☐ Pudding Thick
☐ Full Liquid ☐ No Change Needed
☐ Nectar Thick ☐ Other *(please specify)* _____
☐ Honey Thick

Dx Allergen/Intolerance Specifications: **no preferences unless associated with medical dx*

Please <u>only</u> mark foods the student should ***avoid***. If needed, a separate care plan can be attached to this document

CHECK ALL THAT APPLY

DAIRY

☐ Fluid Milk: offer lactose-free milk
☐ Fluid Milk: do <u>not</u> offer lactose-free milk
☐ Cheese ☐ Ice Cream ☐ Yogurt
☐ Recipes/food products/labels with any type of dairy listed as an ingredient

EGG

☐ Whole egg (scrambled, boiled, fried)
☐ Recipes/food products/labels with any egg listed as an ingredient

SOY

☐ Recipes/food products/labels with any soy listed as an ingredient

OTHER

☐ Other *(Specify)* _____

WHEAT

☐ Recipes/food products/labels with any wheat listed as an ingredient
☐ All forms of Gluten (includes: wheat, oat, barley, rye)

NUTS

☐ Peanuts ☐ Tree Nuts
☐ Other: _____

SEAFOOD

☐ Fish ☐ Shellfish
☐ Other: _____

SESAME

☐ Sesame

Indicate any other comments such as substitutions, feeding patterns, specialized equipment, other restrictions, etc.:

School-based personnel do not routinely have instrumentation and/or training for a comprehensive nutrition and feeding assessment. Please refer student to proper medical authority for comprehensive nutrition and feeding assessment.

Signature of Physician/Medical Authority*	Printed Name	Date
Medical Office Stamp	Office Phone Number	Fax Number

* A recognized medical authority in North Carolina includes licensed physician, physician assistant, nurse practitioner, and registered dietitian.