MACON COUNTY SCHOOLS

CHILD NUTRITION DEPARTMENT

Medical Statement for Students with Special Nutritional Needs for School Meals

(PLEASE NOTE: If form is being completed for food allergy reasons, both sides of form MUST BE COMPLETED)

Part A (To be completed by Parent/Guardian)

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

Student ID # _____ School _____ Grade _____

Will student eat breakfast at school? ☐ Yes ☐ No

Will student eat lunch at school? ☐ Yes ☐ No

Will the student eat snack in the after school program? ☐ Yes ☐ No

Name of Parent/Guardian: _____

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

Phone number(s): _____ (W) _____ (H) _____ (Cell)

Does the child have an identified disability? ☐ Yes ☐ No

If yes, describe the major life activities affected by the disability:

Does the child have special nutritional or feeding needs?

☐ Yes ☐ No

If Yes, have a licensed physician complete Part B of this form and sign it.

If the child does not have an identified disability, does the child have special nutritional or feeding needs?

☐ Yes ☐ No

If Yes, have a licensed physician or recognized medical authority complete Part B of this form and sign it.

signature of parent/guardian	printed name	telephone number	date

Part B Diet Order (To be completed by Physician)

Specify any dietary restrictions or special diet::

List any foods that cause food allergies or intolerances that should be avoided:

If student has life threatening allergies, check appropriate box(es): ☐ingestion ☐contact ☐inhalation

Designate consistency requirements for food:

Blenderized Liquid ☐ Puree ☐

Mechanical Soft ☐ Soft ☐

Designate consistency requirement for liquids:

Thin ☐ Nectar-thick ☐

Honey-thick ☐ Spoon-thick ☐

For any special diet, list specific foods to be omitted and suggested substitutions; You may attach a separate page with additional information.

a. Foods To Be Omitted	b. Suggested Substitutions

Indicate any other comments about the child's eating or feeding patterns:

signature of physician/medical authority*	printed name	telephone number	date

* A licensed physician's signature is required for participants with a disability. For participants without a disability, a licensed physician or medical authority must sign the form.

Part C (For School Use Only)

Form Received by: _____ Date: _____

Please initial or check below when completed:

Copy sent to: School Nurse_____ Child Nutrition Manager_____ VIP/More@4_____Teacher_____ CN Director_____