Medical Plan of Care for School Nutrition Program
(Students with Disabilities and Non-Disabling Special Dietary Needs)
Page 1 is to be completed by a parent/guardian
Page 2 is to be completed by a licensed physician

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7CFR Part 15B require substitutions or modifications in school nutrition program meals for children whose **disability** restricts their diet and is supported by a statement signed by a **licensed physician**.
- Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability"; as well as any other dietary restrictions which substantially limit one or more major life activities.
- The school food authority must choose to accommodate a student with a **disabling special dietary need** that is supported by a statement signed by a **licensed medical authority** (physician, physician assistant or nurse practitioner).
- The school food authority may choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **licensed medical authority**.
- Gainesville City School Nutrition Program provides information based on label information provided to us and cannot guarantee that food products served are not processed in plants that also process nuts or other allergens.
- Labeled foods will only note the presence of eight major allergens: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat and soybeans. **While efforts will be made to avoid other allergens, the Gainesville City School District cannot guarantee that labels will disclose all possible allergens.**
- If you have specific questions, please contact the School Nutrition Department at 770-536-5275.

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Child's Name			Date of Birth	M F
Name of School/Center/Program			Grade Level/Classroom	
Parent's/Guardian's Name			Address, City, State, Zip Code	
( ) Home Phone		( ) Work Phone		

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize ___________________________________ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to ____ (school/program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on ___________________ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or official representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:____ Date:_______________________
(Signing this section is optional, but may prevent delays by allowing us to speak with the physician)

If the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 2: Parent Signature	Date

Additional Parent Comments:

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Part 3: To be completed by Physician/Medical Authority

Disability/Special Dietary Needs

Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability", as well as other dietary restrictions which substantially limit one or more major life activities.

Does the child have a **disability**? Yes ☐ No ☐

If Yes,

Please identify the disability and describe the major life activities affected by the disability.

Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

If the child **does not have a disability***, does the child have special nutritional or feeding needs? Yes ☐ No ☐

(*These accommodations are optional for schools to make)

If Yes, please identify the medical or other special dietary condition which restricts the diet.

If the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 4: To be completed by Physician/Medical Authority

Diet Order

List any dietary restrictions, such as food allergies or intolerances (list specific foods to be omitted):

List specific foods to be added in place of omitted foods **(substitution cannot be made unless section is completed)**:

Example for peanut allergy and egg: "serve meal that does not contain allergens, such as chicken sandwich, hamburger, chicken nuggets, chicken salad w/ roll"

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:

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

Physician/Medical Authority Printed Name and Office Phone Number		Address or Office Stamp
Physician/Medical Authority's Signature*		Date

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*Please make sure specific suggestions are made for substitute foods when omitting foods from the child's diet. School menus are on the district website for your convenience.

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent confirmed no change in diet order. ____ Date ________ ____ Date _______ ____ Date________

____ Date________ ____ Date ________ ____ Date ________ ____ Date ________ ____ Date_______

A copy of this form should be kept by the School Nutrition Manager and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school nutrition services.

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