New Albany-Floyd County Consolidated School Corporation School Health Services
2014-2015 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 of_____breakfast calories ❑Amount of _____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.
❑ 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

***If medication required 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 _____

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR