

SASD Medical Plan of Care for School Food Service

Form Instructions

Summary

- ◆ Parents/Guardians requesting a milk substitution in a school lunch should complete Part 1 and Part 2. (*Note: Lactaid or soy milk are the only permitted substitutes*)
- ◆ Parents/Guardians requesting specific foods for special dietary needs or substitutions due to a disability should complete Part 1 and Part 5, and have a physician or recognized medical authority (*physician, physician assistant or nurse practitioner*) complete Part 3 and Part 4.

Part 1 *Completed by Parent/Guardian for all requests for special dietary needs*

- All parent's/guardians with a student with special dietary needs should complete **Part 1**.

Part 2 *Requests for milk substitution for non-disabling special dietary needs ONLY*

- If a student does not have a **disabling** special dietary need, parent's/guardians should complete **Part 2** and return the form to the school nurse.
 - ◆ Can be completed by a parent/guardian **OR** a recognized medical authority (*physician, physician assistant or nurse practitioner*).
 - ◆ Only for requesting a milk substitute in the school lunch. The only fluid milk substitute offered for a non-disabling dietary need is lactaid or soy milk.

Part 3 *Statement of Disability - To be completed by Physician/Medical Authority*

- Must be completed by a Physician or Recognized Medical Authority.
- This section declares that student has a medical disability that affects the students nutritional needs.

Only a physician or recognized medical authority can classify a student's dietary need(s) as disabling.

Part 4 *Diet Order - To be completed by Physician/Medical Authority*

- Must be completed by a Physician or Recognized Medical Authority.
- Lists all foods that substitutes must be provided for as well as what specifically must be substituted and in what form.

Part 5 *Parent or Guardian Signature*

- Any parent/guardian that has had a physician or recognized medical authority complete Parts 3 and 4 must sign in this section.

Health Insurance Portability and Accountability Act Waiver

Please read this waiver and sign as appropriate. Signing is optional but may prevent delays by allowing the school nurse or Food Service Director to speak directly with the physician regarding your child's special diet needs.

Return the completed form (*as applicable*) to the school nurse.

The school nurse will forward a copy to the Food Service Director to accommodate special dietary needs.

Part 4 - continued

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 pattern:

Physician's Name and Office Phone Number

Office Stamp

Physician/Medical Authority's Signature

Date

Part 5

Parent or Guardian Signature

Signature

Date

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 Shippensburg Area School District Food Services 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 _____.

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

Parent/Guardian Signature: _____

Date: _____

Area below for SASD Office Use only

School Nurse Signature

Nurse signature

Date

It is recommended that parent's/guardian's 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 _____

School Nurses and the Food Service Department should keep copy of this form. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service.