Medical Statement for Students with Unique Mealtime Needs

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), and U.S. Office for Civil Rights (OCR) for meal modifications in any Child Nutrition Program.

PART A *(To be completed by **PARENT/GUARDIAN**)*

STUDENT INFORMATION	**Last Name:**	**First Name:**	**Middle Name:**	**Date of Birth**
	School:		**Grade/Age**	**Student ID# or Meal #**

SELECT the Program: (Select all that apply)

☐ **School Breakfast Program (SBP)** ☐ **National School Lunch Program (NSLP)**

☐ **Afterschool Snack Program (ASP)** ☐ **Fresh Fruit & Vegetable Program (FFVP)**

☐ **Child and Adult Child Care Program (CACFP)** ☐ **Summer Food Service Program (SFSP)**

PARENT/GUARDIAN CONTACT INFORMATION	**Printed Name of PARENT/GUARDIAN:**				
	Mailing Address:		**City:**	**State:**	**Zip Code:**
	Work Phone:	**Island**	**Cell Phone:**	**Email:**	

Please describe the concerns you have about your student's nutritional needs:	
Please describe the concerns you have about your student's ability to safely participate:	

Does the student have an Individualized Education Program (IEP)?
☐ YES ☐ NO

Does the student have a 504 Plan?
☐ YES ☐ NO

NOTE: *Unique mealtime needs for students without an IEP, 504 or disability, but with general health concerns, are addressed within the meal pattern at the discretion of the School, CACFP or SFSP Sponsor.*

PARENT/GUARDIAN Consent

I agree to allow my child's health care provider and school personnel to communicate as needed regarding the information on this form.

Parent/Guardian Signature **Date**

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's school, CACFP or SFSP provider.

STUDENT NAME:		STUDENT ID#:	

PART B *(To be completed by a **RECOGNIZED MEDICAL AUTHORITY**, i.e., Licensed physicians, physician assistants, and nurse practitioners)*

Describe the student's physical or mental impairment:	**Explain how the impairment restricts the student's diet:**

Major life activities affected: *Select all that apply.*

☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Performing manual tasks
☐ Learning ☐ Breathing ☐ Self-Care ☐ Eating/Digestion
☐ Adaptive Equipment *(please specify):*

Is this a Food Allergy? ☐ YES ☐ NO

Is this a Food Intolerance? ☐ YES ☐ NO

If student has life threatening allergies* check appropriate box(es):

**Students with life threatening food allergies must have an emergency action plan in place at school.*

☐ Ingestion ☐ Contact ☐ Inhalation

Specify any dietary restrictions or special diet instructions for accommodating this student in school meals:

For *any* special diet, list specific foods to be omitted and the recommended substitutions. *(You may attach a separate care plan)*

Foods to be Omitted →	Recommended Substitutions	Foods to be Omitted →	Recommended Substitutions

Indicate if the student requires a modified FOOD texture:

☐ N/A
☐ Pureed ☐ Full Liquid
☐ Ground ☐ Clear Liquid
☐ Chopped
☐ Mechanical Soft
☐ Other *(please specify):*

Indicate if the student requires a modified LIQUID consistency:

☐ N/A
☐ Nectar-thick
☐ Honey-thick
☐ Pudding-thick
☐ Other *(please specify):*

Other comments about the child's eating or feeding patterns, including tube feeding if applicable:

***NOTE* If your assessment of the child does not yield sufficient data to fully complete the above sections applicable to the student's mealtime needs, please refer the child/family to the appropriate health care professional for completion of the assessment.**

Signature of Recognized Medical Authority*	Printed Name	Phone Number	Date
		( )	

**** A recognized medical authority in HI includes licensed physicians, physician assistants, naturopathic physician, nurse practitioners, or osteopathic physician.***

PART C *To be completed by **CNP ADMINISTRATORS NSLP, CACFP, SFSP, FFVP**)*

SFA/SPONSOR Administrator's Signature: **Date:**

IEP/504 Coordinator Signature: **Date:**

NOTES: *(School Nutrition, School Program, CACFP or SFSP Administrator only)*

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's school, CACFP or SFSP provider.

Received on:_____
Processed date:_____