Medical Plan of Care for School Food Service
(Students with Disabilities and Non-Disabling Special Dietary Needs)

- ***Student with a Disability:*** Complete this entire form. USDA regulations 7CFR Part 15B require substitutions or modifications in school 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.”
- ***Non-disabled student seeking a special dietary accommodation other than milk substitutions:*** Complete this entire form. The school may choose to accommodate a student with a non-disabling special dietary need that is supported by a statement signed by a recognized medical authority (physician, physician assistant or nurse practitioner).
- ***Non-disabled student seeking a substitution milk:*** Complete part 1 and 2 only. The school food authority may choose to make a milk substitution available for students with a non-disabling special dietary need, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. A parent/guardian or recognized medical authority may complete this section.

Part 1: To be completed by Parent/Guardian

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

Part 2: Request for milk substitution for non-disabled students

To be completed by Medical Authority or Parent/Guardian

SCASD provides approved, nutritionally equivalent ***soy based milk*** as a milk substitute to students with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district. Federal regulations do not permit the use of bottled water or juice as a milk substitute.

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk? Yes ☐ No ☐

Medical or other special dietary need:

Lactose Intolerance ☐ Non-Life-Threatening Milk Allergy ☐ Religious, Ethnic, Cultural Belief ☐

Medical Authority or Parent/Guardian Signature:________________________________ Date:____________

Part 3: Request for special diet (other than milk substitution for non-disabled students)

To be completed by Physician/Medical Authority

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

If Yes, Please describe the major life activities affected by the disability:

Whether the child is disabled or not, does the child have special nutritional or feeding needs? Yes ☐ No ☐

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: Diet Order

To be completed by Physician/Medical Authority. Signed by the Physician, Parent, and Child Nutrition Director.

List any dietary restrictions, such as food allergies, intolerances or restrictions:

List specific foods to be substituted (Substitution cannot be made unless section is completed): *Only nutritionally equivalent soy milk can be provided as a substitute for milk to accommodate students with non-disabling special dietary needs.		
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's Name and Office Phone Number		Office Stamp
Physician/Medical Authority's Signature		Date
Parent Signature		Date
School Nutrition Director 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 the State College Area School District 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 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)

FOR OFFICE USE ONLY/ANNUAL RECORD UPDATE:
The information on this form should be updated annually to reflect the current needs of the student. 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 Food Service and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school food service. **Return completed form to:** Return to: **Holy Trinity Catholic School 5519 6th Avenue, Altoona PA 16602**