

## **Instructions for Special Dietary Needs Prescription Form**

MCSO School Nutrition Program will make modifications and substitutions to the regular school meals for a student with a disability that restricts their diet. Parents / guardians seeking modifications to the school meal are asked to provide the MCSO Special Dietary Needs Prescription Form, completed and signed by a physician, or a copy of a current Section 504 Accommodation Plan. Completed documentation must be provided to the School Nutrition Program, including the school cafeteria Manager and the Special Needs Dietitian. The school cafeteria staff will prepare a modified meal along with the other meals being served that day to ensure the accommodation is made.

Follow these steps to ensure a student with a disability requiring special nutrition needs is served the proper diet in the school breakfast, lunch, and snack programs:

1. Provide completed Special Dietary Prescription Form.
2. Regulations require that this documentation to be filed for each modified meal. This documentation must be on file in the school cafeteria and nurse's office, and with the Special Needs Dietitian. If you have any concerns about this requirement, please contact us immediately to discuss.
3. Please communicate with the cafeteria Manager and the Special Needs Dietitian to know what foods will be served at school.
4. The dietitian, school nurse, or other health professional may suggest that the special dietary needs be included in the Individual Education Plan (IEP) or the 504 Plan, as appropriate.

MCSO School Nutrition Program accommodates dietary needs or religious preferences where appropriate. Such determinations are made on a case-by-case basis. For further information, please visit USDA's Student Nutrition website at <http://www.fns.usda.gov/cnd/Guidance/>.

## Special Dietary Needs Prescription Form

Parents: Please provide a **fully completed form signed by a licensed physician** or a **504 Plan** for a child with a disability in order for a student to receive modifications or substitutions to the regular school meals.

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

Student Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_

Diagnosis(es): \_\_\_\_\_

504 Plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Describe the Student's:  Disability  Medical Condition that requires the student to have a special diet and the major life activity affected by the student's disability or condition:

\_\_\_\_\_  
\_\_\_\_\_

History of anaphylaxis reaction due to severe food allergy:  Yes  No

(If yes, please provide documentation)

Does your child use an EPI pen?  Yes  No

History of allergy testing to indicate food allergy:  Yes  No Date: \_\_\_\_\_

List food(s) to be omitted from the diet and food(s) that may be substituted:

\_\_\_\_\_  
\_\_\_\_\_

Registered Dietitian consulting with the patient:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Physicians Name: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Please complete and return as soon as possible.

Thank you.

To be completed by office:

Clinic Worker/RN contacted:  Yes  No

School cafeteria Manager contacted:  Yes  No

POS system updated:  Yes  No

This institution is an equal opportunity provider.