MADISON CONSOLIDATED SCHOOLS

Educating All Students to Reach Their Potential

2421 Wilson Avenue
Madison, IN 47250
Phone: 812-274-8001

Medical Statement for Students with Special Dietary Needs in Child Nutrition Programs

PART A

Student's Name: _____ **Age:** _____

School Name: _____ **Grade:** _____ **Classroom:** _____

Guardian Name: _____ **Phone:** _____

1. **Does the child have a disability?** ❒ **YES** (Answer #2) ❒ **NO** (Answer #3)
   If Yes, describe the disability/diagnosis and the major life activity affected by the disability.

_____

_____

2. **Does the child have special nutritional or feeding needs that require accommodations <u>within</u> the USDA meal pattern?** If yes, complete Part B of this form and have it signed by a **<u>health care provider with prescriptive authority or the parent</u>.** ❒ **YES** ❒ **NO**

3. **Does the child have special nutritional or feeding needs that require accommodations <u>outside</u> the USDA meal pattern?** If yes, complete Part B of this form and have it signed by a **<u>health care provider with prescriptive authority</u>.** ❒ **YES** ❒ **NO**

PART B

<u>Diet Prescription:</u> (use back of form if more space is needed)

List any dietary restrictions or special diets: _____

List any allergies or food intolerances to avoid: _____

List allowable food substitutions: _____

_____

List food that needs the following change in texture. If all food needs to be prepared in this manner, indicate "All."

❒Chopped: _____

❒Finely Ground: _____

❒Pureed: _____

❒Liquid Modifications: Honey/Nectar/Other (specify) _____

List any special equipment or utensils that are needed and any additional comments about the student's eating patterns or dietary modifications: _____

_____

Parent or Guardian: _____ Date: _____

Signature

Physician or Medical Authority: _____ Date: _____

Signature

_____ Phone: _____

Please Print