Medical Statement to Request a Special Diet

POLICIES

This guidance is based on the policy guidelines outlined in the Food and Nutrition Services Instruction 783-2, Revision 2, Meal Substitutions for Medical or Other Special Dietary Reasons.

Under Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

An IEP (Individualized Education Program) must be completed. An IEP is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA (Individuals with Disabilities Education Act) and its implementing regulations. The IEP is the cornerstone of the student's educational program that contains the program of special education and related services to be provided to a child with a disability covered under the IDEA.

USDA regulations 7CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions in foods when that need is supported by a statement signed by a licensed physician. The Physician's statement must identify:

- The child's disability
- An explanation of why the disability restricts the child's diet
- The major life activity affected by the disability
- The food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted, including changes in food texture

Children with food allergies or intolerances DO NOT have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA, and the school food service may, but is not required to, make food substitutions for them. However, when in the licensed physician's assessment, food allergies may result in severe, life-threatening (anaphylactic) reactions, the child's condition would meet the definition of "disability", and the substitutions prescribed by the licensed physician must be made.

When a child with disabilities requires a change in a diet order, the parent must provide documentation with accompanying instructions from a licensed physician. This is required to ensure that the modified meal is reimbursable, and to ensure that any meal modifications meet nutrition standards which are medically appropriate for the child.

PROCEDURES

1. Assess student
2. Complete IEP as appropriate
3. Obtain a Completed *Medical Statement to Request a Special Diet*.
4. Submit Completed *Medical Statement to Request a Special Diet* to Health Services Fax # 702 799-8671
5. If any changes in diet are required, submit a revised *Medical Statement to Request a Special Diet* completed and signed by a Medical Professional.
6. Special Diet Requests must be renewed annually by submitting a new *Medical Statement to Request a Special Diet*.

CLARK COUNTY SCHOOL DISTRICT
6350 E. Tropical Parkway Las Vegas, NV
89115 702-799-8123

MEDICAL STATEMENT TO REQUEST A SPECIAL DIET

Parent/Guardian: Complete Items 1 - 6 (Pader/tutor: Compleata cajitas 1-6)

1) Student's Last Name *(Apellido del Estudiante)*	Student's First Name *(Nombre del Estudiante)*	Student # *(Número del Estudiante)*	2) Date of Birth *(Fecha de nacimiento)*	3) Circle Meals Eaten at School *(Circule las comidas que su nino/a come en la escuela)* Breakfast (Desayuno) Lunch (Amuerzo)
4) Parent/Guardian Signature *(Firma del Padres/Tutor)*	5) Print Name of Parent *(Escriba en letra de molde el nombre del Padre/Tutor)*			6) Parent Phone Number(s) *(Numero(s) de telefono del Padre/Tutor* Home *(Casa):* ( )_____ Cell *(Celular):* ( )_____

School Nurse: Complete Items 7 - 11

7) School Name		8) Year Round School: ☐ Yes ☐ No
9) School Nurse	10) School Nurse's Phone #	11) School Fax #

PHYSICIAN ONLY: Complete Items 12 - 21

12) If the Student has a disability, medical condition or severe food allergy warranting a special diet, please complete the remainder of this form.

The disability or medical condition must limit a major life activity such as breathing or learning, and the food allergy must result in a reaction that is life-threatening and/or severely impacts the student's ability to function in school.

13) Describe the Disability, Medical Condition, or Severe Food Allergy:

_____

14) What is the Severe and/or Life Threatening Reaction:

_____

15) Diet Order : (what foods should be avoided)

_____

16) If a Documented Dairy Allergy, Must Check Appropriate Choice(s)

☐ **No Milk To Drink** ☐ **No Dairy Products at all (including milk, cheese, yogurt and food containing dairy)** ☐ **Provide Soy Milk**

17) Texture Modification: If needed, circle one appropriate for student: -¼" CHOPPED - ½" CHOPPED - GROUND* - PUREED

18) Physician's Signature	19) Physician's Printed Name	20) Telephone Number
21) Date		

Fax Completed Form to 702-799-8671
Any diet order changes (including texture) require a new signed diet order.
This form must be submitted annually based on date on line 21.
Forms can be found On the CCSD Website or by visiting the school Health Office.
* Ground= Mechanical Soft