PINELLAS COUNTY SCHOOLS - FOOD AND NUTRITION

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

☐***New*** Request ☐***Change***/Modify Existing Request ☐***Discontinue*** Request

(Instructions for completion on reverse side)

SECTION 1: STUDENT INFORMATION – COMPLETED BY THE PARENT/GUARDIAN

1. Student First and Last Name	2. Student ID	3. Student DOB (MM/DD/YYYY)

4. Name of School/Center

5. Name of Parent/Guardian	6. Parent/Guardian Email Address

7. Does this student have an IEP or 504 plan in place that includes dietary restrictions?	8. Meals Eaten at School (check all that apply):
☐ Yes ☐ No	☐ Breakfast ☐ Lunch ☐ Snack ☐ Dinner

9. I understand that, as a parent, it is my duty to update this form **any time there is a change or discontinuation of dietary needs** and to return this form to the school café manager. I give Pinellas County Schools FNS permission to speak with the state licensed medical authority to discuss dietary needs as ordered.

X_____ _____ _____

PARENT/GUARDIAN SIGNATURE | TODAYS DATE | CONTACT NUMBER OF PARENT/GUARDIAN

10. ☐ Check this box to ***DISCONTINUE*** existing dietary accommodation from student's account (please sign box #9 then submit).

SECTION 2: ACCOMMODATION – COMPLETED BY LICENSED MEDICAL AUTHORITY

11. Does the student have a physical or mental disability which restricts the student's diet? ☐ Yes* ☐ No

***If Yes**, describe or state the student's **disability** or **diagnosis**. Explain why it restricts the student's diet and list major life activities affected by the disability:

12. Check off the type of food allergy or allergies:

☐ Egg – whole
☐ Egg – as ingredient, cooked
☐ Wheat
☐ Gluten
☐ Tree nuts
☐ Peanuts
☐ Fish
☐ Shellfish
☐ Soy
☐ Soy – soy lecithin included
☐ Sesame seeds
☐ Milk – as beverage
☐ Milk –as ingredient or by product (cheese, yogurt, etc.)
☐ Other (specify in box #13)

13. Other Foods to be omitted (if not listed):

_____
_____
_____

14. Recommended Substitutions (if any):

_____
_____

15. **Texture Modification:** If needed, please complete additional form (Section 4).

SECTION 3: SIGNATURE – COMPLETED BY LICENSED MEDICAL PROFESSIONAL

16. Printed Name of State Licensed Medical Authority	17. Title			
	☐ Physician (MD, DO)	☐ Physician's Assistant (PA)	☐ Advanced Nurse Practitioner (ARNP)	☐ Registered Dietitian (RDN, RD)
18. Signature of State Licensed Medical Authority	19. Date Signed *VALID UNTIL STUDENT CHANGES SCHOOLS*			
20. Medical Office Address	21. Medical Office Phone Number			

INTERNAL USE ONLY

Date Received:	Date Copy Given to Student Health:	Date Copy Given to Food Service:

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

SECTION 1: STUDENT INFORMATION – COMPLETED BY PARENT/GUARDIAN

1. **Student First and Last Name:** Print the first and last name of the student to whom the information pertains.
2. **Student ID:** Print the PCS ID number of the student.
3. **Student DOB:** Print the date of birth the student.
4. **Name of School/Center:** Print the name of the school that is providing the form to the parent or guardian.
5. **Name of Parent/Guardian:** Print the name of the person requesting the student's medical statement.
6. **Parent/Guardian Email Address:** Print the email address of the person requesting the student's medical statement.
7. **IEP or 504 including dietary restriction:** Check (✓) a box to indicate whether the student has an IEP or 504 plan in place that includes dietary restrictions on their student record.
8. **Meals Eaten at School:** Check (✓) a box to indicate which meals the student typically eats in café at school/center.
9. **Responsibility Acknowledgment and Permission to Speak to Medical Authority:** Signature and email address of the person requesting the student's medical statement, acknowledging in that it is their responsibility to update this form anytime there is a change or discontinuation of dietary needs and to give to school café manager. The signature also gives Food and Nutrition special diets team permission to speak to with the state licensed medical authority and/or parent/guardian to discuss dietary needs, in accordance the provisions of the Healthy Insurance Portability and Accountability Act (HIPPA) OF 1996 and the Family Educational Rights and Privacy Act (FERPA). Print the date the parent or guardian signed the document. You may rescind permission to release information at any time, except when information has already been released.
10. **Discontinue Statement:** Check (✓) box if the purpose of the form is to discontinue an existing meal accommodation for the student

SECTION 2: ACCOMMDATION – COMPLETED BY LICENSED MEDICAL AUTHORITY

11. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Check (✓) a box to indicate whether the student has a disability or does not have a disability. If "Yes" is checked (✓), describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
12. **Food Allergy or Allergies:** Check (✓) all foods that student cannot have, if applicable.
13. **Omitted Foods:** Add any additional life-threatening food allergen(s) that the student is allergic too that is not currently listed in box #12. You may use this box to add any additional information on allergen(s) or refer to additional document.
14. **Suggested Recommendations:** Print any suggested substitutions for previously listed or checked food allergens/omissions.
15. **Texture Modification:** Check (✓) a box to indicate whether the student needs a texture modification. If the student does not need a texture modification, check "Regular."

SECTION 3: SIGNATURE – COMPLETED BY LICENSED MEDICAL AUTHORITY

16. **Printed Name of State Licensed Medial Authority:** Name of the medical authority requesting a special meal or accommodation.
17. **Title:** Check (✓) to choose a box that describes the licensed medial authority's credentials.
18. **Signature of State Licensed Medical Authority:** Signature of the medical authority requesting a special meal or accommodation.
19. **Date Signed:** Print the date the medical authority signed the form.
20. **Medical Office Address:** Print the address of the medical authority.
21. **Medical Office Telephone:** Print the telephone number of the medical authority.

DEFINITIONS*

"A Person with a disability" is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.

"Major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.

"Has a record of such an impairment" is defined as having a history of or has been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

*(*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)*

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

☐***New*** Request ☐***Change***/Modify Existing Request ☐***Discontinue*** Request

SECTION 4: TEXTURE MODIFICATION – COMPLETED BY LICENSED MEDICAL AUTHORITY

22. **Texture Modification***: If needed, select one appropriate solid & liquid for the student.

Solids (Select one):

☐ Pureed (Applesauce/Pudding Texture) – Level 4
☐ Minced & Moist (former Mechanical Soft Ground Diet) - Level 5
☐ Soft & Bite-Sized (former Chopped Diet) - Level 6

Please indicate any additional instructions:

_____

_____

Liquids (Select one):

☐ Student **CAN** drink regular thin liquids (i.e. milk, juice, water) with meals.
☐ Student **CANNOT** drink regular thin liquids (i.e. milk, juice, water) with meals.

Please indicate any additional instructions:

_____

_____

**Texture modification aligns with IDDSI (https://www.iddsi.org/standards/framework) recommendations*

SECTION 5: DISCONTINUTION TEXTURE MODIFICATION – COMPLETED BY THE PARENT/GUARDIAN

23. ☐ Check this box to ***DISCONTINUE TEXTURE MODIFICATION*** for existing dietary accommodation from student's account.

SECTION 6: SIGNATURE – COMPLETED BY LICENSED MEDICAL PROFESSIONAL				
24. Printed Name of State Licensed Medical Authority	25. Title			
	☐ Physician (MD, DO)	☐ Physician's Assistant (PA)	☐ Advanced Nurse Practitioner (ARNP)	☐ Registered Dietitian (RDN, RD)
26. Signature of State Licensed Medical Authority	27. Date Signed *VALID UNTIL STUDENT CHANGES SCHOOLS*			
28. Medical Office Address	29. Medical Office Phone Number			

INTERNAL USE ONLY

Date Received:	Date Copy Given to Student Health:	Date Copy Given to Food Service:

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

SECTION 4: TEXTURE MODIFICATION – COMPLETED BY LICENSED MEDICAL AUTHORITY

22. **Texture Modification:** Check (✓) a box to indicate whether the student needs a texture modification. If the student does not need a texture modification, check "Regular." Please specify any additional instructions or relevant information needed to safely feed students.

SECTION 5: DISCONTINUTION TEXTURE MODIFICATION – COMPLETED BY THE PARENT/GUARDIAN

23. **Texture Modification Discontinuation:** Check (✓) box if the purpose of the form is to discontinue existing meal accommodation for the student.

SECTION 6: SIGNATURE – COMPLETED BY LICENSED MEDICAL PROFESSIONAL

24. **Printed Name of State Licensed Medial Authority:** Name of the medical authority requesting a special meal or accommodation.
25. **Title:** Check (✓) to choose a box that describes the licensed medial authority's credentials.
26. **Signature of State Licensed Medical Authority:** Signature of the medical authority requesting a special meal or accommodation.
27. **Date Signed:** Print the date the medical authority signed the form.
28. **Medical Office Address:** Print the address of the medical authority.
29. **Medical Office Telephone:** Print the telephone number of the medical authority.