PAULDING COUNTY SCHOOL DISTRICT- NUTRITION SERVICES
140 Bethel Church Rd OFFICE: 770-443-8003 x 20236 FAX: 770-920-7071
Medical Plan of Care for School Nutrition Program
EATING AND FEEDING EVALUATION
STUDENT WITH SPECIAL NUTRITION NEEDS

Dear Parent/Guardian,

It is the goal of Paulding County School Nutrition Services to ensure that our students receive the safest and most appropriate food items daily.

If you believe your child requires a special diet, the attached form must be completed and returned to the School Nutrition Office. Special diet requests will be reviewed and created in the order they are received. If your student is eligible for a special diet based on this information, we will then develop a plan that meets your student's needs.

The guidelines for receiving a special diet are as follows:

• A student whose licensed physician/physician assistant/nurse practitioner certifies that the student has a qualifying disability i.e. severe, life threatening allergic (anaphylactic) reaction may qualify.

• Students who receive meal accommodations based on current specific dietary accommodations in their 504 Plan or IEP will receive those accommodations, but we do ask for the most current information as dietary needs change.

Thanks,

PAULDING COUNTY SCHOOL NUTRITION SERVICES

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

Fax: (202) 690-7442

Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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PART A - PARENT COMPLETE

The "Healthy, Hunger-Free Kids Act" requires schools to follow strict meal patterns and dietary specifications. Meals for children with medical disabilities that restrict their diet are not affected by the new meal patterns. The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs. USDA regulations 7CFR Part 15B require substitutions or modifications in school nutrition 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."

In order to make modifications or substitutions to the school meal, schools must have a written Medical Statement on file that is signed by a licensed physician.

Student's Name	**Student ID#**	**Age**

Name of School	**Grade Level**	**Teacher-Homeroom**

Does the student have a disability? If Yes, describe the major activities affected by the disability.	**Yes**	**No**

Does the student have special nutrition needs? If Yes, have Physician complete and sign Part B of this form.	**Yes**	**No**

Parent's Signature-REQUIRED-Authorizes school district to contact physician for clarification	**Parent's Printed Name-REQUIRED**	**Date**
	Parent's Phone-REQUIRED/Email	

PART B – PHYSICIAN COMPLETE

List any dietary restrictions or special diet.	**Medical diagnosis that indicates the special nutrition need/diet- REQUIRED**

List any NON-ANAPHYLACTIC food allergies or food intolerances.

List any ANAPHYLACTIC food allergies.

List foods that may be allowed or substituted.

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." (Circle texture below)

Chopped Ground Pureed - Additional Instructions:

List any special equipment/utensils needed and comments about the child's eating patterns.

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 **Paulding County 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. 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 official 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)

Physician or Medical Authority's Signature-REQUIRED	**Physician or Medical Authority's Printed Name/Address or Stamp-REQUIRED**	**Date**
Physician or Medical Authority's Phone		

ACCOMMODATIONS CANNOT BE EVALUATED WITHOUT PHYSICIAN'S SIGNATURE

School Nutrition Use Only

Fax completed form to SCHOOL NUTRITION 770-920-7071, Attn: Kimberly Blackmon, MBA Wellness Manager or scan & email to kblackmon@paulding.k12.ga.us