State Schools Medical Plan of Care for School Nutrition Program
Eating and Feeding Evaluation Form

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**.

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

DATE IMPLEMENTED:

Child's Name		Date of Birth	M F
Name of School/Center/Program		Grade Level/Classroom	
Parent's/Guardian's Name		Address, City, State, Zip Code	
( ) Home Phone	( ) Work Phone		

Does the child have a **disability**? Yes ☐ No ☐

If the student does not require special meals, the parent can sign at the bottom and return the form to the school food service department.

Religious or other preferences MAY be accommodated at the discretion of the school nutrition department.
List:_____

Does the student have an identified disability and an Individualized Education Program (IEP) or 504 Plan?
☐ **Yes** ☐ **No**

To be completed by Physician/Medical Authority

Part 2: **Disability/Special Dietary Need**

Please identify the disability and describe the major life activities affected by the disability.
Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

Student Diagnosis or Condition:
☐ Food Allergy ☐ Food Intolerance *☐ Life threatening Allergy (Check appropriate box(es) - ☐ Ingestion
☐ Contact ☐ Inhalation
*Students with life threatening food allergies must have an emergency action plan in place at school.

Part 3
Designate texture modifications for FOOD:

☐ Pureed ☐ Mechanical Soft ☐ Chopped ☐ No Change

☐ Other (Specify)

_____

_____

_____

Part 4: To be completed by Physician **Diet Order**

List any dietary restrictions (list specific foods to be omitted):

_____

_____

_____

List specific foods to be substituted (substitution cannot be made unless section is completed):

_____

_____

_____

List any special equipment or utensils needed:

Physician recommended diet:

_____Nothing by mouth (NPO) *Prescription provided to family for formula supplement / Formula provided for school feeds by parent. Initial:_____

_____By mouth (PO) Type Diet: Regular ( ) Chopped ( ) Pureed ( )
Liquids:

Regular_____Thickened_____ / Thickened Consistency: Nectar_____Honey_____Pudding_____
_____ Formula Supplement to school meal (ORAL ONLY) _____ Formula G-Tube Feed
Name of Formula_____ (Substitute allowed? Yes / No)
Amount at each feeding_____
Time(s) to be fed_____
Amount of water_____CC
Amount of water to flush_____CC

Type of G-Tube Feeding: Bolus_____ Slow Drip_____ Pump_____ / Pump Setting:
_____

Swallow study done? Yes No CIRCLE ONE (If yes, please attach if available and indicate Date:_____/_____/_____)

Other information regarding the diet:
_____

Allergy/Intolerance Specifications: Provide any appropriate substitutions. If needed, a separate care plan can be attached to this document. **To be completed by Physician**

CHECK ALL THAT APPLY

DAIRY
☐ Fluid Milk
☐ Recipes with milk as an ingredient
☐ Yogurt
☐ Cheese
☐ Ice Cream
☐ Other_____

WHEAT
☐ Recipes/food products with any wheat listed as an ingredient

NUTS
☐ Peanuts

☐ Tree nuts

SEAFOOD

☐ Specify_____

EGG

☐ Whole Egg such as scrambled or boiled

☐ Recipes/food products with any egg

SOY

☐ Recipes/food products with any soy listed as Ingredient

OTHER

☐ other (Specify)_____

Indicate any other comments about the child's eating or feeding patterns:

Physician Printed Name and Office Phone Number		Address or Office Stamp
Physician's Signature		Date
Part 5: Parent Signature		Date
Part 6: School Nutrition Program Director Signature		Date
Part 7: School IEP Coordinator Signature		Date

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 _____ to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (school/program) and I consent to allow the physician 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. My permission to release this information will expire on _____ (date). 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)

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician.

Parent confirmed no change in diet order. ____ Date _____ ____ Date _____ ____ Date_____

____ Date_____ ____ Date _____ ____ Date _____ ____ Date _____ ____ Date_____

A copy of this form should be kept by the School Nutrition Manager and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school nutrition services.

"This institution is an equal opportunity provider and employer."