

2020-21 MEDICAL REFERRAL FORM FOR MODIFIED SCHOOL MEALS

Form must be submitted yearly if modified meals are necessary.

Please complete this form YEARLY if your child has a food allergy or needs meals changed due to disability.

If your child DOES NOT require changes in regularly served school meals, please DO NOT complete this form.

USDA regulations 7 CFR, 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 a statement signed by a licensed physician supports that need. The physician's statement must identify: (1) the child's disability; (2) an explanation of why the disability restricts the child's diet; the major life activity affected by the disability; (3) the food or foods to be omitted from the child's diet and the foods that must be substituted. This form is in effect from July 1, 2019 through June 30, 2020. **This record must be submitted each school year, if modified meals are needed.**

STUDENT NAME: _____	DATE: _____
SCHOOL: _____	DATE OF BIRTH: _____
PARENT/GUARDIAN: _____	PHONE NO. : _____
ADDRESS: _____	ZIP: _____
SPECIAL DIET/MODIFIED MEALS REQUIRED: _____	
FOOD ALLERGY ___ YES ___ NO	
PLEASE LIST ANY FOOD ALLERGIES: _____	
IS STUDENT LACTOSE INTOLERANT? ___ YES ___ NO	
PARENT/GUARDIAN NAME _____	PHONE NO. _____
EMERGENCY CONTACT _____	PHONE NO. _____
I hereby give permission for the health care provider completing and signing the back of this form to verify this information with HCPS and consult with HCPS staff regarding this information.	
_____ Signature of Parent/Guardian	_____ Date

THIS FORM MUST BE SIGNED BY A PHYSICIAN (*OTHER SIDE*) AND PARENT/GUARDIAN.

TO BE COMPLETED BY PHYSICIAN'S OFFICE

Hancock Co. Schools has been requested to serve this participant modified meals in the Child and Adult Care Food Program (CACFP). To ensure that in so doing, the participant's medical requirements are being met appropriately, we request that you complete this form on the child's behalf. This form, in its entirety, must be completed and submitted each year to ensure that the physician's current diet order is in effect for the child.

STUDENT NAME: _____ SCHOOL: _____

Does the Student have a disability? _____ YES _____ NO
If yes, briefly describe the major life activities affected by the disability.

Does the Student have special nutritional or feeding needs? _____ YES _____ NO
If yes, please describe.

If this student is not disabled, does he/she have special nutritional or feeding needs? _____ YES _____ NO
If yes, please explain and complete this form.

List any dietary restrictions or special diet.

List all food allergies especially life threatening food allergies and describe the severity of each.

List foods/ingredients, which should not be served to this student. (The Child Nutrition Services Department is not responsible for monitoring reduction diets or adult diet restrictions.)

List all suggestions for substitute foods, which may be served.

Please list any texture modifications that are needed and the specific consistency required.

Print Physician's Name: _____ Office Phone # _____

Physician's Office Address _____ Zip Code _____

Physician's Signature: _____ Date: _____

PLEASE RETURN THIS COMPLETED FORM TO:

Hancock County Public Schools – Child Nutrition Services
Phone: (270) 927-6914 Fax: (270) 927-6916