

**MACON COUNTY SCHOOLS
CHILD NUTRITION DEPARTMENT**

Medical Statement for Students with Special Nutritional Needs

(PLEASE NOTE: If form is being completed for food allergy reasons, both sides of form MUST BE COMPLETED)

Part A (To be completed by Parent/Guardian)			
Name of Student: (Last) _____		(First) _____ (Middle) _____	
Student ID # _____	School _____	Grade _____	
Will student eat breakfast at school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will student eat lunch at school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will the student eat snack in the after school program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Parent/Guardian: _____			
Mailing Address: _____		City: _____	State/Zip: _____
Phone number(s): _____ (W)		_____ (H)	_____ (Cell)
Does the child have an identified disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the major life activities affected by the disability: Does the child have special nutritional or feeding needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, have a licensed physician complete Part B of this form and sign it.		If the child does not have an identified disability, does the child have special nutritional or feeding needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, have a licensed physician or recognized medical authority complete Part B of this form and sign it.	
signature of parent/guardian	printed name	telephone number	date
Part B Diet Order (To be completed by Physician)			
Specify any dietary restrictions or special diet::			
List any foods that cause food allergies or intolerances that should be avoided:			
If student has life threatening allergies, check appropriate box(es): <input type="checkbox"/> ingestion <input type="checkbox"/> contact <input type="checkbox"/> inhalation			
Designate consistency requirements for food:		Designate consistency requirement for liquids:	
Blenderized Liquid <input type="checkbox"/>	Puree <input type="checkbox"/>	Thin <input type="checkbox"/>	Nectar-thick <input type="checkbox"/>
Mechanical Soft <input type="checkbox"/>	Soft <input type="checkbox"/>	Honey-thick <input type="checkbox"/>	Spoon-thick <input type="checkbox"/>
For any special diet, list specific foods to be omitted and suggested substitutions; You may attach a separate page with additional information.			
a. Foods To Be Omitted		b. Suggested Substitutions	
Indicate any other comments about the child's eating or feeding patterns:			
signature of physician/medical authority*	printed name	telephone number	date
* A licensed physician's signature is required for participants with a disability. For participants without a disability, a licensed physician or medical authority must sign the form.			
Part C (For School Use Only)			
Form Received by: _____ Date: _____			
Please initial or check below when completed:			
Copy sent to: School Nurse _____	Child Nutrition Manager _____	VIP/More@4 _____	Teacher _____ CN Director _____

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