

Medical Statement for Students with Special Nutritional Needs for School Meals
 Cumberland County Schools 810 Gillespie Street Fayetteville, NC 28306
 Phone: 910-678-2502 Fax: 910-678-2542

Part A (To be completed by Parent/Guardian)			
Name of Student: (Last) _____		(First) _____ (Middle) _____	
Student ID # _____	School _____	Grade _____	
Will student eat breakfast from cafeteria? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will student eat lunch from cafeteria? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will the student eat snack in the after school snack program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Parent/Guardian: _____			
Mailing Address: _____		City: _____	State/Zip: _____
Phone number(s): _____ (Work) _____ (Home) _____ (Cell)			
What concerns do you have about your student's nutritional needs at school or your student's ability to safely participate in mealtime at school?			
Does the student have an identified disability (IEP or 504 Plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes and you have concerns about nutritional needs, have a licensed physician complete Part B of this form and sign it. Return completed form to contact at the top of this page.			
If No and you have concerns about nutritional needs, have a licensed physician or recognized medical authority complete Part B of this form and sign it. Return completed form to contact at the top of this page. Special dietary needs for students without IEP or 504 plans are accommodated at the discretion of the Child Nutrition Administrator and policies of the school district.			
signature of parent/guardian	printed name	telephone number	Date
Part B Diet Order (To be completed by Licensed Physician)			
Student Diagnosis or condition:		Describe major life activities affected:	
Specify any dietary restrictions or special diet instructions for school meals:			
List any foods causing 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:	
<input type="checkbox"/> Clear Liquid	<input type="checkbox"/> Pureed	<input type="checkbox"/> Thin	<input type="checkbox"/> Honey-like
<input type="checkbox"/> Full Liquid	<input type="checkbox"/> Mechanical Soft	<input type="checkbox"/> Nectar-like	<input type="checkbox"/> Spoon-thick
<input type="checkbox"/> Blenderized Liquid			
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 students with a disability. For students without a disability, a licensed physician or medical authority must sign the form.			
Part C (To be completed by Child Nutrition Services)			
Child Nutrition Services Notes:			
CN Administrator Signature: _____		Date: _____	

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