DeKalb County School District
DEPARTMENT OF EXCEPTIONAL EDUCATION AND SUPPORT SERVICES
5839 Memorial Drive
Stone Mountain, Georgia 30083
(678) 874-7002 (Margaret Harris School)
Fax (678) 874-7010

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."
- The school food authority may choose to accommodate a student with a **non-disabling special dietary need** that is supported by a statement signed by a **recognized medical authority** (physician, physician assistant or nurse practitioner).

The school food authority may choose to make a milk substitution available for students with a **non-disabling special dietary need**, such as milk intolerance or for cultural or religious beliefs. If the school food authority makes these substitutions available, the milk substitute must meet nutrient standards identified in regulations. If available, this will be indicated in Part 2. A **recognized medical authority** (physician, physician assistant, or nurse practitioner) may complete this section.

PHYSICIAN AND PARENT AUTHORIZATION FOR ORAL FEEDINGS AND/OR TUBE FEEDINGS

School Year 20____ to 20____

STUDENT'S NAME: _____ DATE: _____

DATE OF BIRTH: _____ SCHOOL: _____

DIAGNOSIS: _____

Please complete the following questions so we may serve the student safely and appropriately.

I. Physician recommended diet:

_____ Nothing by mouth (NPO)
_____ By mouth (PO) Type diet:
_____ Regular

___Chopped
___ Puree-indicate texture below
___ Baby Cereal
____Mashed Table Foods
____ Regular Table Foods

Liquids:
Regular_____
Thickened _____ If thickened, what consistency?
Nectar _____ Honey_____ Pudding _____

____ Stage 1 Baby Foods (smooth)
____Stage 2 Baby Food (semi-chunky)
____ Stage 3 Baby Foods (chunky)

_____ Supplement to school meal
_____ Solids only by mouth
_____ Liquids by G-tube/J-tube (**Circle One**)
_____ Tube Fed

Name of Formula _____
Can a formula of similar nutrient value be substituted? Yes No
Amount at each feeding _____
Times to be fed _____
Amount of water _____
Amount of water to flush _____

II. Type of Feeding:

_____ Bolus
_____ Slow Drip
_____ Pump If pump, what setting _____

III. Swallow study done? Yes No (Circle One) If yes, please attach if available.

IV. Request for <u>milk substitution for non-disabling special dietary needs only</u>
☒ School/school district provides **<u>Lactose Free Milk</u>** as a milk substitute to students with non-disabling or other special dietary needs when Section IV is completed by Medical Authority and approved by the school/school district. **Water is available for all students.**

Does the child have a non-disabling medical or special dietary need that restricts intake of fluid milk?
Yes ☐ No ☐

List medical or special dietary need (e.g., lactose intolerance or for cultural or religious beliefs):
Medical Authority or Parent/Guardian Signature:_____
Date:_____

V. To be completed by Physician/Medical Authority

Does the child have a disability? Yes ☐ No ☐
If Yes,
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 ☐

If the child does not have a disability*, does the child have special nutritional or feeding needs?
Yes ☐ No ☐
(*These accommodations are optional for schools to make)
If Yes, please identify the medical or other special dietary condition which restricts the diet.

<u>Disability/Special Dietary Needs</u>
VI. Contraindications/Precautions and/or Food Allergies, List any dietary specific foods to be omitted:
(To be completed by Physician or Medical Authority) _____

List any specific foods to be substituted (substitutions cannot be made unless this section is filled out)

_____
Physician/Medical Authority Printed Name, Address Office Phone Number

_____ _____
Physician/Medical Authority Signature Date

_____ _____
Parent/Guardian Signature Date