Food Service Office
SUMTER SCHOOL DISTRICT
4255 Peach Orchard Road • PO Box 909 • Dalzell, South Carolina 29040-909 • (T) 803.499.5950 • (F) 803.499.5949

Letter to Physician/Medical Authority
Requesting Instructions for Meal Substitutions for Disabilities, Allergies or Intolerances

August 2017

Dear Physician or Medical Authority:

To allow the school food service department to comply with the USDA Child Nutrition Program regulations for meeting a student's special dietary needs, information must be provided using one of the enclosed forms. Please select the form to be completed based on the descriptions provided:

1. **Medical Statement for Student with Disability Requiring Special Meals:** A student with a disability is to be provided substitutions in foods only when supported by a statement signed by a physician licensed by the state. A "disabled person" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment. The supporting statement must identify:
   a. The individual's disabling condition and an indication how the disability restricts the child's diet;
   b. The major life activity affected by the condition;
   c. The food or foods to be omitted from the child's diet and the food or choice of foods that must be substituted.
   d. Time frame of meal modification (if applicable).

OR

2. **Medical Statement for Student with Food Allergy or Intolerance:** A school will withhold and, at its discretion, may make substitutions for a student who is NOT disabled but is unable to consume food items because of food intolerances or allergies. A recognized medical authority, such as a physician, physician's assistant or nurse practitioner, must sign a supporting statement. The supporting statement must include:
   a. An indication that the medical or other special dietary need restricts the child's diet and
   b. The food or foods to be omitted from the child's diet and
   c. The food or choice of foods that may be substituted.
   d. Time frame of meal modification (if applicable).

Until complete information is received from your office, the student's special diet cannot be implemented. Your timely assistance is appreciated. It is extremely important for the parent/guardian to sign the Medical Statement. If the student's school needs to clarify the diet prescription, the physician or medical authority can provide further information ONLY if the parent/guardian has signed the Medical Statement. Please retain a copy of the completed Medical Statement with your medical records for the student.

If you have questions or need assistance, please call Leon Williams at 803-499-5950.

Sincerely,

Leon Williams

Leon Williams, MBA, CPM
Director, Food and Nutrition Services

Enclosures: Medical Statement for Student Requiring Special Meals due to Food Allergy or Intolerance
Medical Statement for Student Requiring Special Meals due to Disability
This institution is an equal opportunity provider.

Medical Statement for Student Requiring Special Meals Due to Food Allergy or Intolerance

Student Name: _____ District: _____

Birth Date: _____ School: _____

Parent Name: _____ School Contact: _____

Address: _____ School Address: _____

Phone: _____ School Phone: _____

To be completed by a recognized medical authority
(i.e. a licensed physician, physician's assistant or nurse practitioner)

The school is not required to provide substitutions for an allergy or food intolerance, and is permitted to do so **ONLY** when omitted foods and appropriate substitutions are specified by a medical authority. If diet modifications are implemented by the school, they will continue until a medical authority specifies that they should be changed or stopped. Parents/guardians are asked to annually request updated instructions for diet modifications from a medical authority.

___ Student has a disability affecting the diet that meets the definition of "disability" as described on the reverse side of this form. If yes, complete Medical Statement for Student Requiring Special Meals Due to Disability.

Diet Prescription (check all that apply):

___ Milk/Dairy Products Allergy – No fluid cow's milk or any other food product made with cow's milk such as cheese, yogurt, dried milk powder, etc. * * * If student has intolerance to milk and/or milk products, then please complete Form 21-G, Request to Omit Fluid Cow's Milk.

___ Other (describe):_____

___ Food allergies – Please check appropriate box(es): ingestion contact inhalation

List the specific food(s) to be omitted and food(s) that may be substituted. If more space is needed for omitted foods or substitutions, please continue on reverse side of form. Specific foods to be omitted and specific foods to be substituted must be listed below or this statement will be returned to the physician/medical authority for clarification.

Meal Modification Start Date:_____ End Date: _____

Omit Foods Listed Below:	**Substitute Foods Listed Below:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Continued on next page

Medical Statement for Student Requiring Special Meals Due to Food Allergies or Intolerances
(continued)

Comments:

Physician/Medical Authority's Certification:
I certify that the student named on this form needs the prescribed food and/or beverage omission(s) and substitution(s) due to his/her food allergy (ies) and/or food intolerance(s).

_____
Medical Authority's Printed Name

_____	_____	_____
Medical Authority's Signature	Phone Number	Date
_____	_____	_____
Preparer or Other Contact's Signature	Phone Number	Date

Parent/Guardian's Consent
I hereby give permission for the school staff to make the prescribed food and/or beverage omission(s) and substitution(s) in my child's school meals. Furthermore, should the school staff require additional information to clarify how to carry out the diet prescription or food omissions and substitutions; I hereby give permission for my child's physician/medical authority to provide any additional information necessary to clarify the diet prescription written on this form.

_____	_____	_____
Parent/Guardian's Signature	Phone Number	Date

Definition of Disability:
Federal regulations governing the Child Nutrition Programs provide that schools must make substitutions in breakfasts, lunches and afterschool snacks for students who are considered to have a disability and whose disability restricts their diet.

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a "person with a disability" means "any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment." The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as:

- Cancer
- Cerebral Palsy
- Drug addiction and alcoholism
- Emotional illness
- Epilepsy
- Food anaphylaxis (severe food allergy)
- Heart disease
- HIV
- Mental retardation
- Metabolic diseases, such as diabetes or phenylketonuria (PKU)
- Multiple Sclerosis
- Muscular Dystrophy
- Orthopedic, visual, speech and hearing impairments
- Specific learning disabilities
- Tuberculosis

Continued on next page

The Individuals with Disabilities Education Act (IDEA) includes the following conditions:

- Autism
- Deaf-blindness
- Deafness or other hearing impairments
- Emotional disturbance
- Mental retardation
- Multiple disabilities
- Orthopedic impairments
- Other health impairments due to chronic or acute health problems, such as asthma, diabetes, nephritis, sickle cell anemia, a heart condition, epilepsy, rheumatic fever, hemophilia, leukemia, lead poisoning, or tuberculosis
- Specific learning disabilities
- Traumatic brain injury
- Visual impairment, including blindness which adversely affects a child's educational performance

Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.
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Medical Statement for Student Requiring Special Meals Due to Disability

Student Name: _____ District: _____

Birth Date: _____ School: _____

Parent Name: _____ School Contact: _____

Address: _____ School Address: _____

Phone: _____ School Phone: _____

To be Completed by a Licensed Physician:
The school will make diet modifications for a disability **ONLY** when omitted foods and appropriate substitutions are prescribed by a licensed physician. If diet modifications are implemented by the school, they will continue until a licensed physician specifies that they should be changed or stopped. Parents/guardians are encouraged to annually request updated instructions for diet modifications from a licensed physician.

Disability:
Identify the disability (see definition on back of form) that causes the student to require diet modifications.

Describe the major life activities, affected by the disability, that require diet modifications.
Diet Prescription: Check all that apply.

_____ Diabetic meal plan. Please specify_____

_____

_____ Gluten-free meal plan. Please omit all products containing wheat, rye, barley and oats.

_____ Modified texture: _____Regular _____Chopped _____Ground _____Pureed
Other (describe): _____

_____ Modified thickness of liquids: _____Regular _____Nectar _____Honey _____Pudding

Other (describe):_____

List the specific food(s) to be omitted and food(s) that may be substituted. If more space is needed for omitted foods or substitutions, please attach an additional page.

Meal Modification Start Date:_____ End Date: _____

Omit Foods Listed Below:	**Substitute Foods Listed Below:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Continued on next page

Special Feeding Equipment: _____

Comments:

Physician/Medical Authority's Certification:

I certify that the student named on this form needs the prescribed food and/or beverage omission(s) and substitution(s) due to his/her food allergy (ies) and/or food intolerance(s).

_____
Medical Authority's Printed Name

_____	_____	_____
Medical Authority's Signature	Phone Number	Date
_____	_____	_____
Preparer or Other Contact's Signature	Phone Number	Date

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