Medical Statement for Students with Unique Mealtime Needs for School Meals

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school. See *"Guidance for Completing Medical Statement for Students with Unique Mealtime Needs for School Meals"* (previous page) for help in completing this form.

Student Information -- *To be completed by **PARENT/GUARDIAN***

STUDENT INFORMATION	**Last Name**	**First Name**	**Middle Name**	**Date of Birth**
	School		**Grade**	**Student ID#**
SELECT the school-provided meals and/or snacks in which this student will participate:	☐ **School Breakfast** ☐ **School Lunch** ☐ **Afterschool Snack**			
PARENT/GUARDIAN CONTACT INFORMATION	**Printed Name of PARENT/GUARDIAN**			
	Mailing Address	**City**	**State**	**Zip Code**
	Work Phone / **Home Phone**	**Mobile Phone**	**Email**	
Please describe the concerns you have about your student's nutritional needs at school:				
PARENT/GUARDIAN Consent	*I agree to allow my child's health care provider and school personnel to communicate as needed regarding the information on this form.* _____ **Parent/Guardian Signature** _____ **Date**			

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's teacher, principal, nurse, Special Education case manager, or Section 504 case manager, School Nutrition Administrator, or the school staff person who gave you the blank form.

PART A: Therapeutic Component *(To be completed by a **RECOGNIZED MEDICAL AUTHORITY**, i.e., Licensed physicians, physician assistants, and nurse practitioners)*

Medical Diagnosis:

Diet Order:

STUDENT INFORMATION	Last Name	First Name	Middle Name	Student ID#

PART B: Texture Component *(To be completed by a **RECOGNIZED MEDICAL AUTHORITY**, i.e., Licensed physicians, physician assistants, and nurse practitioners)*

Designate safest diet level requirement for FOOD:

Dysphagia Diet (IDDSI)
- ☐ Level 4: Pureed
- ☐ Level 5: Minced & Moist
- ☐ Level 6: Soft & Bite Sized
- ☐ Level 7: Easy to Chew
- ☐ Level 7: Regular

Non-Dysphagia Modifications

Cut All Food:
- ☐ **In Half**
- ☐ **Bite-Sized Pieces (1")**
- ☐ **Small Bite-Sized Pieces (.5")**

Designate safest viscosity level for LIQUIDS:
- ☐ Level 0: Thin
- ☐ Level 1: Slightly Thick
- ☐ Level 2: Mildly Thick
- ☐ Level 3: Moderately Thick
- ☐ Level 4: Extremely Thick

Other Directions:

***NOTE* If your assessment of the child does not yield sufficient data to fully complete the above sections applicable to the student's mealtime needs, please refer the child/family to the appropriate health care professional for completion of the assessment.**

Signature of Recognized Medical Authority*	Printed Name	Phone Number	Date
		( )	

**** A recognized medical authority in N.C. includes licensed physicians, physician assistants and nurse practitioners.***

Medical Office Stamp:

PART C: Child Nutrition Information Only *(To be completed by Child Nutrition Services)*

School Nutrition Administrator's Signature: Date:

School Nutrition Administrator's Signature (Second Review, If Applicable): Date:

NOTES: *(School Nutrition or other School Program staff)*

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(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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