

## Diet Request for Meals at School

\*See other side for related information. This form is NOT to be used for Life Threatening Allergies.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby give my permission for the school staff to follow the stated nutrition plan below. I give my permission for the medical provider and for the school health/ nutrition personnel to communicate based on this statement if needed. Communication, if needed, may only include the statement and nutrition plan, implementation of the nutrition plan in school and student outcomes of the plan.

Sign Here

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### FOR HEALTHCARE PROVIDER

What is the student's dietary condition?

What are the needs?

If lactose intolerant, please specify one (or more) of the following:

- No plain milk, may have chocolate milk
- No fluid milk but MAY have baked products with cheese or other dairy products in ingredients, etc.
- No fluid milk but MAY have baked or uncooked products with dairy including cheese, yogurt, pudding, ice cream, etc.
- No milk products including no fluid milk, cheese, yogurt, pudding, ice cream, etc.
- No milk products and no products prepared with dairy i.e. no breads, desserts or other products prepared With milk or dairy
- OTHER: \_\_\_\_\_
- Gluten intolerant** (See "Food Substitution Medical Statement for Students Requiring Special Meals and/or Accommodations" form if student has life threatening allergy to wheat or has diagnosed Celiac Disease)

Comments: \_\_\_\_\_

Other: \_\_\_\_\_

Sign Here

\_\_\_\_\_  
Healthcare Provider SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED Healthcare Provider NAME

\_\_\_\_\_  
PHONE NUMBER



Forward Thinking, High Achieving.

## Special Dietary Needs

### Dear Parent/Guardian and Healthcare Provider:

The following is an explanation of the Missoula County Public Schools (MCPS) Food Substitution forms.

Additional information may be obtained from: MCPS Food and Nutrition Supervisor: Stacey Rossmiller /728-2400 ex 3023/ [srossmiller@mcps.k12.mt.us](mailto:srossmiller@mcps.k12.mt.us)

### MCPS has two meal related forms;

1. Food Substitution Medical Statement For Students Requiring Special Meals and/or Accommodations
  - a. Must be completed by a Licensed Physician
  - b. For students who are considered to have a disability that requires dietary accommodations
2. Diet Request for Meals at School
  - a. Completed by a healthcare provider
  - b. Used for food intolerances, mild non-life threatening allergies or other conditions that are not disabilities as defined below.
  - c. The school may provide standard food substitutions on a case by case basis.

### Information on Disability Determination

#### United States Department of Agriculture (USDA) Regulations:

For schools participating in a federally-funded school nutrition program, USDA regulations 7 CFR Part 15b require substitutions or modifications in school meals for students whose **disabilities** restrict their diets. A student with a disability or medical condition must be provided substitutions in foods when that need is supported by a statement signed by a licensed physician. A physician is a person licensed by the State to practice medicine. The term includes physicians or doctors of osteopathic medicine. These fully trained physicians are licensed by the State to prescribe medication or to perform surgery. The physician's statement must identify:

- a. The student's disability or medical condition
- b. An explanation of why the disability restricts the student's diet
- c. The major life-activity affected by the disability
- d. List the food or foods to be omitted from the student's diet
- e. List the food or choice of foods that must be substituted

#### Definitions 1

USDA FNS Instruction 783-2, 7 CFR Part 15b

**Disability:** Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, "person with a disability" means any person who has a physical or mental impairment which **substantially limits** one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

**Physical or mental impairment:** means (1) any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic skin and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; metabolic diseases such as diabetes and phenylketonuria (PKU); food anaphylaxis; mental retardation; emotional illness; and drug addiction and alcoholism.

**Major life activities:** are defined as caring for one's self, eating, performing manual tasks, walking, standing, lifting, bending, seeing, hearing, speaking, sleeping, breathing, learning, reading, concentrating, thinking, communicating and working. A major life activity also includes the operation of a bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.