Dear Parent,

If your child will require a special diet or will need the school meal to be modified due to a medical condition, please complete the Medical Statement for Student’s Requiring Special Meals (see back of page). This form is required before we can provide your student with anything other than the standard school meal.

Required information includes:
- the child’s disability
- an explanation of how the disability restricts the child’s diet
- the food or foods to be omitted from the child’s diet, and the food or choice of foods that need to be substituted.

Please ensure the detailed diet information is provided on the medical statement stating the level of omission of the food allergen or foods that your child is intolerant to. This information is necessary to ensure your student be provided with the foods that are appropriate to their specific dietary restrictions. For example, if your student cannot have milk we need to know if they cannot have milk to drink or if they cannot have any milk or dairy products at all in their diet.

To ensure our kitchen staff are adequately informed and prepared to accommodate your student’s special diet please allow 5 days to implement your child’s diet into the school meal program. As much advanced notice about a student needing a special diet is appreciated.

Please complete the Medical Statement for Student’s Requiring Special Meals form and turn it into your schools health office or fax it to Nutrition Services at 531-299-0416. Feel free to contact Krista Niles at 531-299-9859 or at krista.niles@ops.org in Nutrition Services for more information on how we can better meet the special diet needs of your student.

We cannot accept a note from a physician on a prescription pad or office letterhead, as it does NOT contain the required information or signatures.

If your child’s diet changes for any reason, please make sure that the Medical Statement for Student’s Requiring Special Meals is either retracted or removed from the health office. It is the policy of Omaha Public Schools, Nutrition Services to follow any medical documentation that is on file. We understand student’s diets do change, but until further documentation is received the original Medical Statement for Students Receiving special meals will be followed.

Please visit the Omaha Public Schools Website at district.ops.org, click on “Parents” then “Lunch Menus” for more information regarding school meals.

Thank you.
MEDICAL STATEMENT FOR STUDENTS REQUIRING SPECIAL MEALS

Nutrition Services Department · Omaha Public Schools

This Statement MUST be updated when there is a change in the diet order.

Name of Student: ___________________________ Student’s Birth Date: ___________________________

Parent Name: ___________________________ Student’s Grade: _______ Student ID #: ___________________________

Parent Telephone: ___________________________ Attending School: ___________________________

Identify and describe the disability, or medical condition, including allergies that require the student to have a special diet. Describe the major life activities affected by the student’s disability. ___________________________

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Child’s Diagnosis or Condition: ___________________________

Does the child have an identified disability, and Individualized Education Program (IEP) Plan or potential for a severe allergic reaction (anaphylaxis) to food? □ Yes □ No

For Physician’s Use

Diet Prescription (check all that apply):

☐ Diabetic: carbohydrate level _______ (attach meal plan) ☐ Modified Texture and/or Liquids

☐ Calorie-Controlled: calorie level _______ ☐ Other (describe): ___________________________

☐ Food Allergy (describe): ___________________________

□ Is this a life-threatening allergy? □ Yes ☐ No

☐ Food Intolerance Type: ___________________________

☐ Soy Milk or ☐ Lactose Free Milk (parent may select)

□ Parent may review menu in advance and select the child’s meals from regular foods provided at school.

Food(s) Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. Attach an additional sheet if necessary. Substitutions are considered optional unless checked.

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<th>Foods to be Omitted</th>
<th>Substitutions</th>
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Indicate Texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Indicate thickness of liquids: ☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ Special Feeding Equipment ___________________________

Additional Comments: ___________________________

I certify that the above named student needs special school meals as described above, due to the student’s disability or chronic medical condition.

* A licensed physician’s (MD or DO) signature is required for students with a disability. For students without a medical diet related disability a licensed physician or recognized medical authority (physician’s assistant (PA), or advanced registered nurse practitioner (ARNP), licensed medical nutrition therapist (LMNT), or a chiropractic physician) may sign the form. An individual with a disability is described under Section 504 of the Rehabilitation Act and the Americans with Disability Act (ADA) as a person who has a physical or mental impairment that substantially limits one or more “major life activities”, including the education day and has a record of such impairment, or is regarded as having such an impairment.

Physician/Medical Authority Signature *  Telephone Number  Date

Signature of Preparer or Other Contact  Telephone Number  Date

I give permission for the school/agency personnel responsible for implementing my child’s prescribed diet order to share information with employees in order to accommodate this food modification request for meals and other activities involving food. □ Yes ☐ No

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Parent’s Signature  Date

Email Contact of Parent  Student ID #  Parent Primary Phone #