Medical Plan of Care for School Food Service
(Students with Disabilities and Non-Disabling Special Dietary Needs)

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 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 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 parent/guardian or **recognized medical authority** (physician, physician assistant, or nurse practitioner) may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

Part 1: To be completed by Parent/Guardian (all requests for special dietary needs)

Child's Name	Date of Birth	M F
Name of School/Center/Program	Grade Level/Classroom	
Parent's/Guardian's Name	Address, City, State, Zip Code	
([ ])		([ ])
Home Phone		Work Phone

Part 2: Request for milk substitution for non-disabling special dietary needs only

School/school district does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2.
School/school district provides _____ as a milk substitute to students with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district.

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:_____

Part 3: To be completed by Physician/Medical Authority
Disability/Special Dietary Needs

Does the child have a **disability**? Yes No
If Yes,
Please 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 the child has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 4: To be completed by Physician/Medical Authority
Diet Order

List any dietary restrictions, such as food allergies, intolerances or restrictions: