

Medical Referral Form
Scott County Schools
For Modified School Meals

Current Federal regulations require that requests for modified meals and special diets be authorized by a medical doctor (USDA policy memo 84-6 and FNS 783-2). For each student requesting modified school meals, this form is to be completed and maintained with the student's health records at school.

1. Note to school personnel: Please complete the identifying information. Send this form, and a return envelope to the student's parent/guardian.

TO BE COMPLETED BY SCHOOL PERSONNEL	
School _____	Date _____
Student _____	Birthdate _____
Parent / guardian _____	Phone _____
Address _____	Zip _____
Special Diet / Modified meals requested _____	

2. Note to parent / guardian: Federal regulations require this information. Your assistance in completing this form is essential and appreciated.

TO BE COMPLETED BY PARENT/GUARDIAN	
Is the special diet request in section 1? Correct? YES _____ NO _____ If not, what is the correct diet for the student? _____	

Signature of Parent / Guardian _____ Date _____	
***If modified meals are <u>not</u> required by the student, return this form to the school.	
***If modified meals <u>are</u> required, send this form and the return envelope to the student's medical doctor for completion of section 3.	
I, _____ (parent name) give my permission for the cafeteria supervisor and/or the school nurse to contact my child's doctor, _____ at _____ (phone number) to clarify anything related to my child's modified diet request.	
Signature of Parent / Guardian _____ Date _____	

3. Note to physician: School Nutrition Services personnel have been requested to serve this student modified meals in the child nutrition programs. To insure that, in so doing, the student's medical requirements are being met appropriately, we request that you complete the form on this page. Should you have any questions, contact the Director of Nutrition Services at (502) 570-3035 for clarification.

TO BE COMPLETED BY PHYSICIAN

1. Is the diet modification designated in section 1. appropriate at this time? YES _____ NO _____

Comments _____

2. If this student requires texture-modified meals, specify: Not applicable _____

Ground Foods _____

Pureed Foods _____

3. Are there foods which should not be served to this student? Yes _____ No _____

If Yes, List foods which should not be served _____

If Yes, also list suggestions for alternative foods which may be served to this student _____

4. Does the student have a disability? Yes _____ No _____

If yes, describe the major life activities affected by the disability. _____

If yes, does the student have special nutritional or feeding needs? Yes _____ No _____

5. If the student is not disabled, does he/she have special nutritional or feeding needs? Yes _____ No _____

6. List any allergies or food intolerances to avoid: _____

Which of these allergies is life threatening? _____

Additional recommendations: _____

Signature of Physician _____ Date _____

Office Address _____ Zip _____ Phone _____

RETURN THIS FORM IN THE ENVELOPE PROVIDED TO THE SCHOOL NUTRITION SITE MANAGER. YOUR PROMPT ATTENTION AND ASSISTANCE ARE APPRECIATED.