



Medical Statement for Students with Special Nutritional Needs for School Meals Lufkin Independent School District

Send a copy of the completed form to: Amanda Calk, RD, LD, LISD Student Nutrition Department, 918 E. Denman Ave. Lufkin, TX 75901 ajcalk@lufkinisd.org Fax: 936-630-4209 Phone: 936-630-7054

| Part A (To be completed by Parent/Guardian) | | | |
|--|--|---|--------------------------------------|
| Name of Student: (Last) _____ | | (First) _____ (Middle) _____ | |
| Student ID # _____ | School/Campus _____ | Grade _____ | |
| Will student eat breakfast from cafeteria? <input type="checkbox"/> Yes <input type="checkbox"/> No | Will student eat lunch from cafeteria? <input type="checkbox"/> Yes <input type="checkbox"/> No | Will the student eat snack in the after school snack program? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Name of Parent/Guardian: _____ | | | |
| Mailing Address: _____ | | City: _____ | State/Zip: _____ |
| Phone number(s): _____ (Work) | | _____ (Home) | _____ (Cell) |
| <p>What concerns do you have about your student's nutritional needs at school or your student's ability to safely participate in mealtime at school?</p> <p>Does the student have an identified disability (IEP or 504 Plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes and you have concerns about nutritional needs, have a medical authority complete Part B of this form and sign it. Return completed form to contact at the top of this page.</p> <p>If No and you have concerns about nutritional needs, have a licensed physician or recognized medical authority complete Part B of this form and sign it. Return completed form to contact at the top of this page. Special dietary needs for students without IEP or 504 plans are accommodated at the discretion of the Child Nutrition Administrator and policies of the school district.</p> | | | |
| signature of parent/guardian | printed name | telephone number | Date |
| Part B Diet Order (To be completed by Licensed Physician or Medical Authority) | | | |
| Student Diagnosis or condition: | | Describe major life activities affected: | |
| Specify any dietary restrictions or special diet instructions for school meals: | | | |
| List any foods causing food allergies or intolerances that should be avoided: | | | |
| If student has life threatening allergies, check appropriate box(es): <input type="checkbox"/> ingestion <input type="checkbox"/> contact <input type="checkbox"/> inhalation | | | |
| Designate consistency requirements for food: | | Designate consistency requirement for liquids: | |
| <input type="checkbox"/> Clear Liquid | <input type="checkbox"/> Pureed | <input type="checkbox"/> Thin | <input type="checkbox"/> Honey-like |
| <input type="checkbox"/> Full Liquid | <input type="checkbox"/> Mechanical Soft | <input type="checkbox"/> Nectar-like | <input type="checkbox"/> Spoon-thick |
| <input type="checkbox"/> Blenderized Liquid | | | |
| For any special diet, list specific foods to be omitted and suggested substitutions; You may attach a separate page with additional information. | | | |
| a. Foods To Be Omitted | | b. Suggested Substitutions | |
| | | | |
| Indicate any other comments about the child's eating or feeding patterns: | | | |
| | | | |
| signature of physician/medical authority* | printed name | telephone number | date |
| * A medical authority (licensed by the State to write medical prescriptions) signature is required for students with a disability. | | | |
| Part C (To be completed by Student Nutrition Services) | | | |
| Student Nutrition Services Notes: | | | |
| | | | |
| SNS Administrator Signature: _____ | | Date: _____ | |

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: **1. Mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or, **2. Fax:** (833) 256-1665 or (202) 690-7442; or **3. Email:** program.intake@usda.gov.