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: 936-634-7054

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? ☐ Yes ☐ No

Will student eat lunch from cafeteria? ☐ Yes ☐ No

Will the student eat snack in the after school snack program? ☐ Yes ☐ No

Name of Parent/Guardian: _____

Mailing Address: _____ City: _____ State/Zip: _____

Phone number(s): _____(Work) _____(Home) _____(Cell)

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?

Does the student have an identified disability (IEP or 504 Plan)? ☐ Yes ☐ No

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.

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.

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): ☐ ingestion ☐ contact ☐ inhalation

Designate consistency requirements for food:		Designate consistency requirement for liquids:	
☐ Clear Liquid	☐ Pureed	☐ Thin	☐ Honey-like
☐ Full Liquid	☐ Mechanical Soft	☐ Nectar-like	☐ Spoon-thick
☐ 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: _____

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