# Medical Statement for Students with Unique Mealtime Needs for School Meals

Charlotte-Mecklenburg Schools

Return completed form to: CMS School Nutrition Services PO Box 668847 Charlotte, NC 28266
Phone (980) 343-6041 Fax (980) 343-6045 specialdiets@cms.k12.nc.us

**DO NOT WRITE IN THIS AREA**

1893540213

## PART A Parent / Guardian: Complete Items 1 - 15 *(Padre/madre/tutor: complete la información en los espacios 1 al 15)*

**Parent/Guardian: It is REQUIRED that this completed form be returned to CMS School Nutrition Services. This form must be completed by a state licensed authorized medical authority each time student's diagnosis or change of treatment is indicated. This written statement will remain in effect until the parent or legal guardian revokes such statement.**
*(Padre/madre/tutor: Se REQUIERE que se devuelva esta planilla debidamente completada a CMS School Nutrition Services. Este formulario debe ser completado por una autoridad médica autorizada con licencia estatal cada vez que se indique un diagnóstico o un cambio de tratamiento del alumno. Esta declaración escrita permanecerá en vigencia hasta que el padre/madre/tutor revoque dicha declaración.)*

* Monthly menus with carbohydrate content in grams and major food allergens are posted at http://cms.nutrislice.com. A completed Diet Order Form is not required if nutrislice information is sufficient for parent/guardian to manage a student's diet at school.
*(El menú mensual, con la información sobre los gramos de carbohidratos y los principales alérgenos de los alimentos se encuentra en http://cms.nutrislice.com. No es necesario completar esta planilla si la información mencionada en nutrislice es suficiente para que los padres/tutores supervisen la dieta del estudiante en la escuela)*

**1) Student's Power School #** *(N° de estudiante)* | **2) Student's Last Name** *(Apellido del estudiante)* | **3) Student's First Name** *(Nombre del estudiante)* | **4) Date of Birth** *(Fecha de nacimiento)*

**5) Request Type** *(Solicitud)*
☐ **Initial Diet Order** *(nueva)*
☐ **Revision to Diet Order** *(revisión)*

**6) School** *(Escuela)* | **7) Grade** *(Grado)*

**8) Meals Eaten at School** *(Los alimentos que su niño(a) consumirá en la escuela)*
☐ **Breakfast** *(Desayuno)* ☐ **Lunch** *(Almuerzo)* ☐ **Snack** *(Merienda)* ☐ **None** *(Nada)*

**Parent/Guardian Contact Information** ***(Información del padre/madre/tutor)***

**9)** Name *(Nombre)* | **10)** Phone Number *(Teléfono)* | **11)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

**12)** E-mail Address (We will use this to send acknowledgement and details of your child´s menu plan. PRINT NEATLY)
*Dirección electrónica (será usada para mandarle la confirmación de recibo y los detalles sobre el menú de su niño(a). IMPRIMA)*

**13) Does the student have an identified disability (IEP or 504 Plan)?** *¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)?* ☐ IEP ☐ 504 ☐ No
Describe concerns you have about your student's nutritional needs and ability to safely participate in meal time at school

**14) Request for fluid milk substitution and cultural/personal preferences do not require medical approval. If you request a substitute for fluid milk, state the medical or dietary need that restricts the student's diet. School Nutrition Services reserves the right to modify the menu based on product availability.**
*(La solicitud de sustitución de la leche fluida y las preferencias culturales/personales no requieren aprobación médica. Si solicita un sustituto de la leche fluida, indique la condición médica o dietética que restringe la dieta del estudiante. School Nutrition Services se reserva el derecho de modificar el menu basado en la disponibilidad de los productos.)*

☐ **Fluid Milk Substitution:** Available options to substitute *(Sustitución de leche: Opciones disponibles para sustituir son:)* ☐ Lactaid Milk *(leche lactaid)* Additional beverages: ☐ 100% Fruit Juice *(bebidas adicionales) (100% jugo de fruta)* ☐ Water *(Agua)*

**Medical or dietary need for this request** *(condición médica o dietética para esta solicitud)* _____

☐ **Cultural/Personal Preferences** *(preferencias culturales/personales)* ☐ **No Pork** *(carne de cerdo)* ☐ **No Beef** *(carne de res)* ☐ **Other** *(otro)* _____

☐ **Other Condition (Must be diagnosed by authorized medical authority using Part B)** *(Otra condición- debe ser autoridad médica reconocida por un médico en la parte B)*

**15) I consent to the exchange of information between the Healthcare Provider and district/school personnel, as needed.**
*(Doy mi consentimiento para que la información sea intercambiada entre el médico y el personal del distrito/escuela, según sea necesario)*

**Parent / Guardian Signature (required for processing)** ***(Firma del padre/madre/tutor*** *- requerido para ser procesado)* X | **Date** *(Fecha)*

## PART B

*(Items 16 - 20 to be completed by a RECOGNIZED MEDICAL AUTHORITY, i.e, Licensed physicians, physician assistants, and nurse practitioners)*
*(Artículos 16 - 20 para ser completado por una AUTORIDAD MÉDICA RECONOCIDA, es decir, médicos con licencia, asistentes médicos y enfermeras practicantes)*

**16) Does the student have a disability, medical condition, or severe food allergy warranting a special diet?** ☐ **Yes** ☐ **No**
If "YES", specify disability below. If "no", a special diet is not warranted. A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

**Disability (specify)** _____

**Describe major life activities affected** ☐ **Eating** ☐ **Learning** ☐ **Digestion** ☐ **Other (specify)** _____

**Student Diagnosis or Condition: For the following diagnosis, section 17 below must be completed to identify which foods must be omitted due to the identified condition:**
☐ Food Intolerance ☐ Food Allergy ☐ *Life Threatening Food Allergy - Check appropriate box: ☐ Ingestion ☐ Contact ☐ Inhalation
***Students with life threatening food allergies must have an emergency action plan in place at school**

**17) Please check all food(s) to omit from the child's meals while at school due to the above noted disability:**

**DAIRY**
☐ Fluid Milk Substitute with ☐ lactose-free milk ☐ juice ☐ water
☐ Cheese and recipes with cheese listed as an ingredient
☐ Ice Cream
☐ Yogurt
☐ Recipes with any dairy listed as an ingredient

**EGG**
☐ Whole eggs such as scrambled eggs or hard cooked eggs
☐ All food items with egg listed as an ingredient including baked goods

**WHEAT / GLUTEN**
☐ Recipes with wheat listed as an ingredient
☐ Recipes with Gluten (wheat, barley, rye, triticale) listed as an ingredient

**PEANUTS OR TREE NUTS**
(CMS cafeterias do not serve peanuts or tree nuts)
☐ Peanuts ☐ Tree nuts

**CORN**
☐ Whole corn such as corn kernels, tortilla chips, corn muffin
☐ Recipes with corn listed as an ingredient (corn syrup, corn starch, etc.)

**SOY**
☐ Soy Lecithin
☐ Soy Protein (concentrate, hydrolyzed, isolate)
☐ Recipes with any soy listed as an ingredient

**FISH OR SHELLFISH** (CMS cafeterias do not serve shellfish)
☐ Fish ☐ Shellfish

**SESAME**
☐ Sesame Oil ☐ Sesame Seed

**OTHER**
☐ Other, specify if it is a cooked ingredient or when consumed fresh

**18) Food Texture Modifications:** If needed check ONE: ☐ Pureed ☐ Ground ☐ Chopped

**19) Other Nutrition Requirements due to documented disability in Section #16:** Please specify:

**20) Recognized Medical Authority* Information** ***Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.***

Signature of Recognized Medical Authority* X | Date | Medical Office Stamp (required for processing)

Printed Name of Recognized Medical Authority*

*A recognized medical authority in N.C. includes licensed physicians, physician assistants and nurse practitioners.