



Medical Statement for Students with Unique Mealtime Needs for School Meals

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

9154476286

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.

* 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) 6) School (Escuela) 7) Grade (Grado) 8) Meals Eaten at School (Los alimentos que su niño(a) consumirá en la escuela)
Initial Diet Order (nueva) Reversion to Diet Order (revisión) 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 IEP or 504 Plan? ¿Ha sido el estudiante identificado con una PEI o Plan 504? 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.

Fluid Milk Substitution: (Sustitución de leche:) Lactaid Milk (leche lactaid) 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) Vegan (vegana) Vegetarian (vegetariana) 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) Date (Fecha)

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

16) Does the student have a medical condition or severe food allergy warranting a special diet? Describe major life activities affected 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:

17) Please check all food(s) to omit from the child's meals while at school due to the above noted medical condition or severe food allergy: DAIRY, WHEAT / GLUTEN, SOY, PEANUTS OR TREE NUTS, FISH OR SHELLFISH, SESAME, EGG, CORN, OTHER

18) Food Texture Modifications: Designate safest consistency, CHOOSE ONE: Pureed Ground Chopped

19) Other Nutrition Requirements due to documented concern 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* Printed Name of Recognized Medical Authority* Date *A recognized medical authority in N.C. includes licensed physicians, physician assistants, nurse practitioners, and registered dietitians.

PART C (To be completed by SCHOOL DISTRICT REGISTERED DIETITIAN) NOTES: (School Nutrition Registered Dietitian)

School Nutrition Registered Dietitian Signature: Date: