Dear Parent or Guardian:
The Powell County School Nutrition Program understands the various nutritional needs of all students. Please read the following to learn about how to request an accommodation to your student(s) meals.

A. If the request is for an accommodation because of disability or food allergy/intolerance.
   1. The Medical Statement for Students with Unique Mealtime Needs for School Meals must be completed and provided to our office/school. All parts of the form must be completed, and
   2. The plan must specifically identify the major life activity affected.
   3. The parent must sign and complete Part A.
   4. The plan must be completed and signed by a Kentucky recognized medical authority (Medical Doctor, M.D., Osteopath O.D., Advanced Registered Nurse Practitioner, ARNP, or Physician Assistant)

PRESCHOOL ONLY: Preschool meals do not use offer v/s serve. Unless the preschool student has a disability, regarding milk (regular or lactose free) milk must be on the student's tray. The medical form will need to include any modifications needed.

If you have any further questions regarding this matter, please call our office at 606-663-3300.
Sincerely,

Laura D. Young
School Nutrition Director

Powell County Schools
Dr. Anthony Orr, Superintendent
691 Breckinridge Street | P.O. Box 430 | Stanton, KY 40380
Phone: (606) 663-3300 | Fax: (606) 663-3303

Dear Parent or Guardian:

Welcome to another year! We recognize the growing number of students who attend our schools that have meal accommodations. We want to minimize the risk by providing parents/guardians with forms to have on file in the school district to help us maintain a safe environment for all students. The information is not only important to the school nutrition department, but also the school nurse who communicates to teachers and other school staff.

Managing food modifications is a shared responsibility between the family and the school. We are providing the forms that will need to be updated. If your child had a previous accommodation form on file this past school year, see the bottom of this letter.

The School Nutrition Director and/or manager are available to set up a time to meet and review the menu choices to plan the modifications for your child's meals including any time during the school year.

We look forward to working together to develop healthy and appetizing meals for your child(ren).

Please mark the appropriate statement below and return to the School Nutrition office or your child's cafeteria manager. If you have any questions regarding this matter, please call our office at 606-663-3300.

Sincerely,

Laura D. Young
School Nutrition Director

Student Name: _____ Date: _____

_____Continue using the information form from the previous year. I will use the new updated form if changes occur during the year.

_____I will be providing new/or updated information

_____My child no longer needs food modifications

_____I need to set up an appointment for reviewing my child's needs.

Parent/Guardian Signature: _____ Date: _____

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Guidance for Completing the Medical Statement for Students with Unique Mealtime Needs for School Meals

PART A- PARENT/GUARDIAN

The *Medical Statement for Students with Unique Mealtime Needs for School Meals* helps schools provide meal modifications for students who require them. Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare providers. Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals and snacks to your child while at school.

Your participation in this process is very important. The sooner you provide this signed and completed form to your child's school, the sooner the School Nutrition Program and their staff can prepare the food your child needs. Your signature is required for your school to take action on the Medical Statement.

Follow these steps to get started:

1) Complete all sections of PART A of the Medical Statement.
2) Take the Medical Statement to your child's medical doctor (M.D.), osteopath (O.D), advanced registered nurse practitioner (ARNP) or physician assistant and have him/her complete **PART B.**
3) RETURN THE FULLY COMPLETED MEDICAL STATEMENT WITH SIGNATURES FROM BOTH PARENT/GUARDIAN AND MEDICAL AUTHORITY, TO YOUR CHILD'S PRINCIPAL, NURSE, SECTION 504 CASE MANAGER, OR SCHOOL NUTRTION STAFF.
4) Ask the school when a team, including you, the school systems School Nutrition Administrator and others, will meet to consider the information provided on the form.
   You may also invite from the community who are knowledgeable about your child's feeding and nutrition issues to the meeting. These would be people who could help school staff design a school meal time plan for your child, like your child's pediatrician, nurse, speech-language pathologist, occupational therapist, registered dietitian or personal care aide.

PART B- RECOGNIZED MEDICAL AUTHORITIES (*medical doctor (M.D.), an osteopath (O.D), advanced registered nurse practitioner (ARNP) or a physician assistant)*

A Recognized Medical Authority's signature is *required* for students with a disability. Schools cannot change food textures, make food substitutions, or alter a student's diet at school without proper documentation from the healthcare providers. Meal modifications are implemented based on medical assessment and treatment planning and *must be ordered by a recognized medical authority.*

Please consider the following as you complete **PART B** of the Medical Statement:

1) Complete all sections of PART B. Completion of all items will streamline efficient care of the student at the school.
2) Be specific as possible about the nature of the student's physical or mental impairment, its impact on the student's diet and major life activities that are affected. In the case of food allergy, please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).
3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications or other dietary restrictions, please refer the child/family to the appropriate health care professional for completion of the assessment.
4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to school.
5) Consider being available to consult with the student's mealtime planning team as it implements the feeding/nutrition care plan.

PART C- SCHOOL NUTRITION ADMINISTRATOR and 504 REPRESENTATIVE/SCHOOL HEALTH PROFESSIONAL

Please consider the following as you complete **PART C** of the Medical Statement:

Signature of the School Nutrition Administrator, 504 Coordinator/IEP Case Manager and School Healthcare Professional indicates the medical statement has been received, reviewed, and a plan to address the student's unique mealtime needs is being developed/implemented.

Medical Statement for Students with Unique Mealtime Needs for School Meals

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school. See "Guidance for Completing Medical Statement for Students with Unique Mealtime Needs for School Meals" (previous page) for help on completing this form.

PART A (To be completed by PARENT/GUARDIAN)

STUDENT INFORMATION	Last Name:	First Name:	Middle Name:	Date of Birth:
	School:		Grade:	Student ID #:

SELECT the school-provided meals and/or snacks in which this student will participate:

☐ School Breakfast Program ☐ National School Lunch Program ☐ Afterschool Snack Program

☐ Afterschool Supper Program ☐ Summer Feeding Program

PARENT/GUARDIAN CONTACT INFORMATION	Printed Name of PARENT/GUARDIAN:			
	Mailing Address:	City:	State:	Zip Code:
	Work Phone: / Home Phone:	Mobile Phone:	Email:	

Please describe the concerns you have about your student's nutritional needs at school:

Please describe the concerns you have about your student's ability to safely participate in mealtime at school?

Does the student already have an Individual Education Program (IEP)?

☐ YES ☐ NO

Does the student already have a 504 Plan?

☐ YES ☐ NO

NOTE: Unique mealtime needs for students without an IEP, 504, or disability, but with general health concerns, are addressed within the meal pattern at the discretion of the School Nutrition Administrator and policies of the school district.

PARENT/GUARDIAN Consent

I agree to allow my child's health care provider and school personnel to communicate as needed regarding the information on this form.

Follow-up Documentation (for schools staff only):

Parent/Guardian Signature: Date:

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's principal, nurse, Section 504 case manager, or School Nutrition staff.

Student Name: _____ Student ID: _____

PART B *(To be completed by a recognized Medical Authority in Kentucky, ie, medical doctor (M.D.), an osteopath (O.D), advanced registered nurse practitioner (ARNP) or a physician assistant is recognized.)*

Describe the student's physical or mental impairment:	Explain how the impairment restricts the student's diet:

Major life activities affected: *Select all that apply.*	☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Performing manual tasks ☐ Learning ☐ Breathing ☐ Self-Care ☐ Eating/Digestion	☐ Other *(please specify)*:

Is this a Food Allergy? ☐ YES ☐ NO Is this a Food Intolerance? ☐ YES ☐ NO	If student life threatening allergies * check appropriate box(es): **Students with life threatening food allergies must have an emergency action plan in place at school.* ☐ Ingestion ☐ Contact ☐ Inhalation

Specify any dietary restrictions or special diet instructions for accommodating this student in school meals:

For *any* special diet, list specific foods to be omitted and the recommended substitutions. *(You may attach a separate care plan.)*	Foods to be Omitted	Recommended Substitutions	Foods to be Omitted	Recommended Substitutions

Designate safest consistency requirement for FOOD:			Designate safest consistency requirement for LIQUIDS:		
☐ Pureed ☐ Mechanical Soft ☐ Ground ☐ Chopped		☐ Other *(Please specify)*:	☐ Clear Liquid ☐ Nectar-thick ☐ Full Liquid ☐ Honey-thick ☐ Pudding-thick		☐ Other *(Please specify)*:

Other comments about the child's eating or feeding pattern, including tube feeding if applicable:	**NOTE* If your assessment of the child does not yield sufficient data to fully complete the above sections applicable to the student's mealtime needs, please refer the child/family to the appropriate health care professional for completion of the assessment.*

Signature of Recognized Authority*	Printed Name	Phone Number ( )	Date

**A recognized authority in KY includes a medical doctor (M.D.), an osteopath (O.D), advanced registered nurse practitioner (ARNP) or a physician assistant.*

PART C *(To be completed by SCHOOL DISTRICT ADMINISTRATORS)*

Notes: *(School Nutrition or other School Program staff)*

School Nutrition Administrator's Signature _____ Date _____

IEP/504 Coordinator Signature _____ Date _____

District Health Professional Signature _____ Date _____