

**MEDICAL STATEMENT FOR STUDENTS WITH ALLERGIES OR STUDENTS
REQUIRING SPECIAL MEALS/SUBSTITUTIONS**
Nutrition Services Department
Lee's Summit R7

This statement **MUST** be updated when there is a change in the diet order.

Name of Student:	Student's Birth Date:
Parent Name:	Student's Grade:
Parent Telephone:	School Attending:
Physician's Name (Please Print)	

I hereby give my permission for the school staff to follow the stated nutrition plan below. I give my permission for nutrition services to contact the above doctor if questions arise.

Parent/Guardian

Date

For Physicians Use (to be completed by a licensed physician)

Identify and describe disability, or medical conditions, including allergies that require student to have a special diet or items eliminated from the diet.

Describe the major life activities affected by the student's disability.

Diet Prescription (check all that apply):

Diabetic: Calorie Level (attach meal plan) Carb Counting (attach meal plan)

Modified Texture and/or liquids

Calorie –Controlled: _____ calorie level

Other (describe): _____

Food Allergy: (Please list each allergy): _____

***Please be specific, if the student has a milk allergy is it fluid milk only or all milk products, if a child has an egg allergy, is it just fresh eggs and eggs baked/cooked in products is ok.

If student has a food allergy, is this a life-threatening allergy? Yes No

Food Omitted and Substitutions:

If foods are listed to be omitted from the diet, **specifics** on foods to substitute **must** be provided.

Foods to Omit:

Foods to Substitute:

Indicate Texture: Regular Chopped Ground Pureed

Indicate thickness of liquids: Regular Nectar Honey Pudding

Special Feeding Equipment: _____

Additional Comments: _____

I certify that the above named student needs special school meals prepared or served or items eliminated as described above because of the student's disability or chronic medical condition.

Licensed Physician or Recognized Medical Authority

Date

Name, including Credentials: _____ Type or Print
Phone: _____
Fax: _____

Signature of Preparer or Other Contact

Please fax or mail to: Lee's Summit R7 Nutrition Services
702 SE 291 Highway
Lee's Summit, Missouri 64063
Fax: 816-986-2215

Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990.

"Disabled person" means any person who has a physical or mental impairment, which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (1) any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sensory organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic skin, and endocrine or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to such diseases as orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction, and alcoholism.

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.