Muscogee County School District
School Nutrition Program

Instructions for Special Dietary Needs Prescription Form

MCSD School Nutrition Program will make modifications and substitutions to the regular school meals for a student with a disability that restricts their diet. Parents/guardians seeking modifications to the school meal are asked to provide the MCSD Special Dietary Needs Prescription Form, completed and signed by a physician, or a copy of a current Section 504 Accommodation Plan. Completed documentation must be provided to the School Nutrition Program, including the school cafeteria Manager and the Special Needs Dietitian. The school cafeteria staff will prepare a modified meal along with the other meals being served that day to ensure the accommodation is made.

Follow these steps to ensure a student with a disability requiring special nutrition needs is served the proper diet in the school breakfast, lunch, and snack programs:

1. Provide completed Special Dietary Prescription Form.
2. Regulations require that this documentation to be filed for each modified meal. This documentation must be on file in the school cafeteria and nurse's office, and with the Special Needs Dietitian. If you have any concerns about this requirement, please contact School Nutrition immediately to discuss.
3. Please communicate with the cafeteria Manager and the Special Needs Dietitian to know what foods will be served at school.
4. The dietitian, school nurse, or other health professional may suggest that the special dietary needs be included in the Individual Education Plan (IEP) or the 504 Plan, as appropriate.

MCSD School Nutrition Program accommodates dietary needs or religious preferences where appropriate. Such determinations are made on a case-by-case basis. For further information, please visit USDA's Student Nutrition website at http://www.fns.usda.gov/cnd/Guidance/.

Special Dietary Needs Prescription Form

Parents: Please provide a **fully completed form signed by a licensed physician** or a **504 Plan** for a child with a disability in order for a student to receive modifications or substitutions to the regular school meals.

Date:_____

Student Name:_____ Student Number:_____

Date of Birth:_____ Grade:_____ School:_____

Diagnosis(es):_____ 504 Plan? Yes_____ No_____

Parent/Guardian:_____ Phone Number:_____

Describe the Student's: ☐ Disability ☐ Medical Condition that requires the student to have a special diet **and** the major life activity affected by the student's disability or condition:

_____

_____

History of anaphylaxis reaction due to severe food allergy: ☐ Yes ☐ No
(If yes, please provide documentation)
Does your child use an EPI pen? ☐ Yes ☐ No
History of allergy testing to indicate food allergy: ☐ Yes ☐ No Date:_____
List food(s) to be omitted from the diet **and** food(s) that may be substituted:

_____

_____

Registered Dietitian consulting with the patient:

Name:_____ Phone Number:_____

Physician's Signature:_____ Phone Number:_____

Physician's: Name:_____ Fax Number:_____

Please complete and return as soon as possible.

Thank you.

To be completed by office:

Clinic Worker/RN contacted: ◯ Yes ◯ No
School cafeteria Manager contacted: ◯ Yes ◯ No
POS system updated: ◯ Yes ◯ No