SUMTER COUNTY SCHOOLS Food Services Department/Health Services	NUTRITION/MENU/DIET MODIFICATION Parent/Guardian Letter

Student's Name	Grade	Date of Birth
School's Name	Home Teacher	School Year

Dear Parent/Guardian(s):

Your child's emergency form lists the following allergies:

☐ Food *(please specify)* _____

☐ Bee/Insect _____

☐ Environmental *(please specify)* _____

☐ Animal *(please specify)* _____

☐ Shellfish _____

☐ Peanuts _____

☐ Milk – If you would prefer to not have your child receive **fluid milk** for lactose intolerance or a milk sensitivity, FSD requires a ***parent note*** be placed on file with the school cafeteria manager and the school health clinic/nurse.

☐ Latex _____

☐ Other *(please specify)* _____

Please have a Physician complete and then return the attached **Menu Modification Medical Statement to Request Special Meals and/or Accommodations** for your student. You may FAX, mail, send or bring this form to your child's school.

Our FAX number is _____

Thank you for your prompt attention to this important matter.

Sincerely,

School Health/Nutrition Services _____ Date _____

USDA Regulation 7 CFR Part 15b requires substitutions or modifications in school meals for children whose disabilities restrict their diets. A disability is defined as a "physical or mental impairment which substantially limits one or more major life activities […]." Food allergies which may result in severe, life-threatening, anaphylactic reactions would also meet the definition of a "disability". A child with a disability must be provided substitutions in foods when that need is supported by a **signed statement from a licensed physician.** When possible, we will *try* to make substitutions for medically certified dietary needs, even if it does not qualify as a disability.

Required Documentation

The Food Service Department (FSD) prepares well-balanced, kid-friendly meals which meet strict nutritional standards set by the United States Department of Agriculture (USDA). Menus incorporate fresh fruit and vegetables, whole grains, low-fat and fat-free dairy products, and lean protein sources that are served at age-appropriate portion sizes.

If a child has a disability relating to food, a food allergy, food intolerance, or special dietary need, a request for assistance with planning and selecting special menus may be made.

Each Dietary Request Requires a Signed Copy of the Attached Menu Modification Medical Statement.

The *Menu Modification Medical Statement* form must be placed on file with the school clinic/nurse and cafeteria manager. For further information regarding documentation or requests, contact the FSD.

Luanne Moon
Food Service Technician

Food Service Department
Sumter County Schools Facilities Building
301 West McCollum Avenue
Bushnell, Florida 33513
Office: 352-793-1281
Fax: 352-793-4277

Special Note:

Due to occasional food substitutions by our supplier and the possibility of cross-contamination of allergens in manufacturing plants as well as the variety of foods brought into the cafeteria by students from home, it is impossible to guarantee an allergen-free cafeteria environment.

Menu Modification Medical Statement
To Request Special Meals and/or Accommodations for School Cafeteria

To be Completed By Parent		
Student's Name:	Grade:	Date of Birth:
School Name:		
Parent/Guardian: (Please Print)	Home Number	Cell Number

To be Completed by Physician

☐ The student **DOES have** a disability or medical condition and requires a special meal or accommodation.

☐ The student **DOES NOT have** a disability but is requesting a special meal or accommodation due to food allergies, intolerance or other medical reasons. Food preferences are not an appropriate use of this form.

Disability or medical condition requiring a special meal or accommodation.

Does the student have a special nutritional need?

If student has a disability, describe the major life activities affected by the disability.

Does the student receive meals from the school cafeteria? Please indicate breakfast, lunch, afterschool snacks _____

Provide the diet prescription and/or accommodation. Please describe in detail. Use extra pages if needed.

List any allergies or food intolerances student needs to avoid.

Indicate Texture Modification Request. ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed ☐ Liquid ☐ Tube Feed

Please list specific foods to be omitted and suggested substitutions. Use extra pages if needed.

Foods to be Omitted	**Suggested Substitutions**
_____	_____
_____	_____

Adaptive Equipment:

Parent/Guardian Signature: Date Signed:

Duration: ☐ Entire school year or until cancelled by physician order.

☐ From _____ to _____ **(Date cannot be for more than one school year)**

☐ I certify that the above named student needs special school food as described above.

Medical Authority's Signature: _____ Printed Name: _____

Phone Number: _____ Date Signed: _____

*A physician's signature is required for students with a disability. For students without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.

(Internal Use Only) Date Received By School: **Date Copy Given To Food Service:**

Recipients Signature: **Recipients Signature:**

School Nurse Signature: