TELL CITY-TROY TOWNSHIP SCHOOLS-CHILD NUTRITION SERVICES

# 2019-2020 MEDICAL REFERRAL FORM FOR MODIFIED SCHOOL MEALS

FORM MUST BE SUBMITTED YEARLY IF MODIFIED MEALS ARE NECESSARY.

## PLEASE COMPLETE THIS FORM YEARLY IF YOUR CHILD HAS A FOOD ALLERGY OR NEEDS MEALS CHANGED DUE TO DISABILITY

If you child **DOES NOT** require changes in regularly served school meals, please **DO NOT** complete this form

USDA regulations 7 CFR, 15B require substitutions or modifications in school meals for children whose disabilities restrict thier diets. A child with a disability must be provided substitutions in foods when a statement signed by a licensed physician supports that need. The physician's statement must identify; (1) the child's disabilty; (2) an explanation of why the disability restricts the child's diet; the major life activity affected by the disability; (3) the food or foods to be omitted from the child's diet and the foods that must be substituted. This form is in effect from July 1, 2019 through June 30, 2020.

**This record must be submitted each school year, if modified meals are needed.**

| | | | |
|---|---|---|---|
| STUDENT NAME: | | DATE: | |
| SCHOOL: | | DATE OF BIRTH: | |
| PARENT/GUARDIAN: | | PHONE NO.: | |
| SPECIAL DIET/MODIFIED MEALS REQUIRED: | | | |
| FOOD ALLERGY | YES | NO | |
| PLEASE LIST ANY FOOD ALLERGIES: | | | |
| IS STUDENT LACTOSE INTOLERANT? | YES | NO | |

| | |
|---|---|
| PARENT/GUARDIAN NAME: | PHONE NO.: |
| EMERGENCY CONTACT: | PHONE NO.: |

**I hereby give permission for the health care provider completing and signing the back of this form to verify this information with TCTTSC and consult with TCTTSC staff regarding this information**

Signature of Parent/Guardian      Date

**THIS FORM MUST BE SIGNED BY A PHYSICIAN*(OTHER SIDE)* AND PARENT/GUARDIAN**

## TO BE COMPLETED BY PHYSICIAN'S OFFICE

Tell City-Troy Township Schools has been requested to serve this particpant modified meals in the Child and Adult Care Food Program (CACFP). To ensure, that in so doing, the particpant's medical requirements are being met appropriately, we request that you complete this form on the child's behalf. This form, in its entirety, must be completed and subhmitted each year to ensure that the physician's current diet order is in effect for the child.

STUDENT NAME: ______________________________ SCHOOL ______________

Does the Student have a disability? Yes ______ No ______
If yes, briefly describe the major life activities affected by the disability.

Does the Student have special nutritional or feeding needs? Yes ______ No ______
If yes, please describe.

If this student is not disabled, does he/she have special nutritional or feec Yes ______ No ______
If yes, please explain and complete this form.

List any dietary restrictions or special diet

List all food allergies especially life threatening food allergies and describe the severity of each.

List foods/ingredients, which should not be served to this student.

List all suggestions for substitute foods, which may be served.

Please list any texture modifications that are needed and the specific consisitency required.

Print Physician's Name: ______________________________ Office Phone # ______________

Physician's Office Address ______________________________ Zip Code ______________

Physician's Signature: ______________________________ Date: ______________

PLEASE RETURN THIS COMPLETED FORM TO:
TELL CITY-TROY TOWNSHIP SCHOOL CORPORATION
837-17TH STREET, TELL CITY, IN
PHONE: 812-547-3300 FAX: 812-547-9704