SY 22/23

Dear Parent/Guardian,

It is the goal of the Fulton County School Nutrition Program to ensure that our students receive safe and most appropriate nutrition daily.

If you believe your child qualifies for a special diet, the attached form must be completed and returned to the Fulton County School Nutrition Program (MenusTeamSNP@fultonschools.org, Fax: 470-254-1241). Special diet requests will be reviewed and created in the order they are received. If your student is eligible for a special diet based on this information, we will contact you to establish a plan that meets your student's needs.

The guidelines for receiving a special diet are as follows:

- Students with disabilities whose licensed physician/physician assistant/nurse practitioner certifies the students require specialized diets or meals because of their disability.
- Form must be filled out by a licensed physician/physician assistant/nurse practitioner.
- Form must be filled out completely. If it is not, there may be a delay in creating and implementing a special diet for your child.
    - Please be sure to include a valid phone number and email address on the form.
- Once your student's special diet menu has been created, a member from our team will email you a copy of the menu for your approval. Once approval has been received, a member from our team will train the café manager and staff on your student's specific dietary requirements and confirm a start date.

For SY 23/24, the form must be filled out AFTER MAY 1, 2023. **New forms are required each school year.** Please review the instructions below to ensure that these forms are received correctly so that we may create a special diet as soon as possible for your child.

If you have questions, please contact us via email at MenusTeamSNP@fultonschools.org or call 470-254-8960.

Thank you,

The Menus Team
School Nutrition Program | Fulton County School System

Fulton County Schools

Medical Plan of Care for School Nutrition Program

For Students with Disabilities that require Special Dietary Accommodations

Page 1 is to be completed by a Parent/Guardian. Page 2 is to be completed by a licensed physician/physician assistant/nurse practitioner.

Please return completed forms to the Fulton County School Nutrition Program, email to MenusTeamSNP@fultonschools.org, or fax to (470) 254-1249 at the Attention of the Menus Team.

The following child is a participant in one of the United States Department of Agriculture (USDA) school nutrition programs.

- USDA regulations 7 CFR Part 15B require substitutions or modifications in school nutrition program meals for children whose **disability** restricts their diet. The purpose of this form is for your licensed physician/physician assistant/nurse practitioner to document this disability.
- Under the Americans with Disabilities Act, any condition that substantially limits a major life activity constitutes a disability.
- Fulton County School Nutrition Program provides information based on label information provided to us and cannot guarantee that food products served are not processed in plants that also process nuts or other allergens.
- Labeled foods will only note the presence of eight major allergens: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat and soybeans. **While efforts will be made to avoid other allergens, the Fulton County School District cannot guarantee that labels will disclose all possible allergens.**
- If you have specific questions, please contact the School Nutrition Department.

Part 1: To be completed by Parent/Guardian

Child's Name:	Date of Birth:	Gender: M F
Name of School:	Grade Level/Classroom:	
Parent's/Guardian's Name:	Address, City, State, Zip Code:	
Phone: / Email Address:		

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ **(medical authority)** to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to the Fulton County School District and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ **(date).** This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian, or official representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____
(Signing this section is optional, but may prevent delays in allowing us to speak with the physician)

Part 2: Parent Signature:	Date:

Part 3: Disability/Special Dietary Needs (To be completed by Physician/Physician Assistant/Nurse Practitioner)
Does the child have a **disability**? Yes ☐ No ☐

If Yes,
Please identify the disability, describe the major life activity or activities affected by the disability:

Does the child's disability affect their nutritional or feeding needs? Yes ☐ No ☐

If the child has a disability that requires a special dietary/feeding need, please have a licensed physician complete Part 4 of this form.

Part 4: Diet Order (To be completed by Physician/Physician Assistant/Nurse Practitioner)
List any dietary restrictions **required** as a result of the student's disability (list specific foods to be omitted):

NOTE: Labeled foods will only note the presence of eight major allergens: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat and soybeans. While efforts will be made to avoid other allergens, the Fulton County Schools cannot guarantee that labels will disclose all possible allergens.

List specific foods to be substituted (substitution cannot be made unless section is completed):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."
Cut up/chopped into bite sized pieces:

Finely Ground:

Pureed:

List any special equipment or utensils needed:

Indicate any other comments about the child's eating or feeding patterns:

Physician/Physician Assistant/Nurse Practitioner Name (Printed)	Office Address and Phone Number:
Physician/Physician Assistant/Nurse Practitioner Signature	Date:

Received Date SHS: _____ Cluster Nurse/Special Education Nurse Signature_____ Date sent to School Nutrition_____

A copy of this form should be kept by the School Nutrition Manager and the Nurse. FERPA allows school nurses to share student's medical information regarding dietary needs with school nutrition services.