CCPS
Collier County Public Schools

PHYSICIAN'S REQUEST FOR MEAL MODIFICATION

Student's Name:_____ ID #:_____ Date of Birth: __/__/__ School/Grade: _____

Parent/Guardian's Name (print):_____ Daytime Phone:_____ Email:_____

Students whose physical or mental impairment (disability) restricts their diet are eligible for meal modification in the School Breakfast and National School Lunch Program. Meal Modifications must be prescribed by a licensed physician, nurse practitioner, or physician's assistant and the required dietary regimen must be specified.

CLASSIFICATION FOR HEALTHCARE PROVIDER USE

1. **"A Person with a disability"** is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.
2. **"Physical or mental impairment"** means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.

(CITATIONS FROM SECTION 504 OF THE REHABILITATION ACT OF 1973 AND AMERICANS WITH DISABILITIES ACT OF 1990)

HEALTHCARE PROVIDER* USE ONLY

1. Explanation of the child's physical or mental impairment and how it restricts the child's diet, including allergies:

   _____

   _____

2. Specify Food Textures: Cut up/chopped in bite-size pieces:_____

   Finely ground: _____

   Pureed: _____

3. Special Feeding Equipment: List any special equipment or specialty utensils needed:_____
4. List foods or beverages that the student **CANNOT** consume:_____
5. List the foods or beverages that **CAN BE SUBSTITUED**:_____
6. Additional information: Child's food likes & dislikes: _____

Health Care Provider Office Name:_____

Address:_____ City:_____ State:_____ Office Phone:_____ Fax:_____

Health Care Provider Name:_____ Health Care Provider Signature:_____ Date:_____

Office Stamp Here:

Parent/Guardian Signature: _____ Date: _____

Return Form to School Nurse/School Office

SCHOOL USE ONLY

Copy of form to:

1. School Nurse 2. School Café Manager 3. Dept. of Nutrition Services Dietitian (email NutritionServices@collierschools.com)

Student Medical History

Student Name _____ **Student #** _____

DOB _____ **School** _____ **Grade** _____ **Teacher** _____

Parent/Guardian Name _____ **Bus Rider**: Yes__ No__

Phone (H) _____ (W) _____ (C) _____

PRIMARY MEDICAL DIAGNOSIS:

_____

_____

Year Diagnosed _____

SIGNS AND SYMPTOMS THAT MAY PRESENT AT SCHOOL:

_____

_____

ACTIONS TO BE TAKEN AT SCHOOL:

_____

_____

CURRENT MEDICATIONS: (Attach additional pages as needed)

Drug Name	*Dose*	*Purpose*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diastat _____ Epi-pen _____ Other _____

SURGERIES: (Attach additional pages as needed)

Type _____ *Year* _____
Type _____ *Year* _____
Type _____ *Year* _____

HOSPITALIZATIONS: (Attach additional pages as needed)

Reason _____ *Year* _____
Reason _____ *Year* _____
Reason _____ *Year* _____
Reason _____ *Year* _____

ALLERGIES: (Attach additional pages as needed)

Allergic to	*Reaction*	*Action*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Student Name _____ **Student #** _____

PRIMARY PHYSICIAN:
Name: _____
Address: _____
Phone: _____ Fax: _____

MEDICAL SPECIALISTS:
Name: _____ Phone: _____
Address: _____ FAX: _____

Name: _____ Phone: _____
Address: _____ FAX: _____

Name: _____ Phone: _____
Address: _____ FAX: _____

General Health History **Enter dates into any boxes that apply to your child's health history**

Past	Present	
		Accidental injuries/severe head injury
		ADHD
		Asthma/respiratory condition
		Bee sting/insect allergy
		Bladder disorder
		Cancer/Tumor
		Diabetes
		Diarrhea/constipation/toileting issues
		Disorder of the blood
		Ear problems
		Emotional concern
		Eye problems/Glasses
		Food, drug, or environmental allergies

Past	Present	
		Frequent colds/flu
		Hearing problems/Hearing devices
		Heart problem
		Kidney disease
		Muscular disorder
		Seizures/convulsions
		Serious infections/high fevers
		Severe burns
		Severe headaches
		Skin problems
		Swallowing or choking difficulties
		Other:
		Other:

Does your child walk independently? Yes _____ No _____
Is any adaptive equipment required? Yes _____ No _____
If yes, please specify:
_____
_____
_____

Does your child have any dietary concerns or feeding / eating problems? Yes _____ No _____
If yes, specify:
_____
_____
_____
_____

Does you child have any activity restrictions? Yes _____ No _____ (If yes, please specify)

_____
_____
_____

Toileting? Specify any special needs

_____
_____
_____

Will your child require any medical treatments while at school? (Ex: nebulizer, injections, tube feeding)

_____
_____
_____

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my child's health. I understand that this information is confidential and will be shared on a need to know basis. This information is protected by law.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information as listed on this Individualized Healthcare Plan.

_____ _____
Signature of Parent **Date**

_____ _____
Reviewed by (Nurse Signature) **Date**