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 Telephone: _____

Students with a disability or medical condition that requires a meal modification/accommodation are eligible for prescribed menu modifications in the School Breakfast and Lunch Program. Meal modifications/accommodations must be prescribed by a licensed physician, nurse practitioner, or physician's assistant* and the required dietary regimen must be specified.

HEALTHCARE PROVIDER* USE ONLY

☐ **The student has a disability** that requires a meal modification/accommodation. A licensed physician must sign this form.

1. Describe the disability or medical condition requiring a meal modification/accommodation: _____
_____

2. ICD 10 Code _____

3. Specify the student's required menu modifications/accommodation. Include change in texture, food preparation, etc.:
_____

4. List foods or beverages that the student cannot consume:_____
_____

5. List the foods or formulas that can be substituted: _____

HEALTHCARE PROVIDER* USE ONLY

☐ **The student does not have a disability** but is requesting a meal modification/accommodation due to medically diagnosed food intolerance or other medical reasons. Food preference requests are not an appropriate use of this form. A licensed physician, physician's assistant, or nurse practitioner must sign this form.

1. Describe the medical condition requiring menu modification/accommodation: _____
_____

2. Specify the requested menu modifications/accommodations for the student:_____
_____

3. List foods or beverages that the student cannot consume:_____
_____

4. List the foods or formulas that can be substituted: _____
_____

*Medical Authority Signature: _____ Printed Name: _____ Date: _____

Address: _____ City: _____ State: _____

Office Phone: _____ Fax: _____

*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 may sign this form.

Parent/Guardian Signature: _____ Date: _____

Copy to: School Nurse, Dept. of Nutrition Services Dietitian, School Nutrition Services Mgr.

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**