NS0002
*Rev. 12/23*

# MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL NUTRITIONAL NEEDS

**Nutrition Services Department**
**(402) 436-1747 • Fax (402) 436-1775**
**Lincoln Public Schools • Lincoln, Nebraska**

Dear Parent or Guardian,

**SPECIAL DIETS FOR ALLERGIES AND MEDICAL CONDITIONS:** If your student has a diagnosed food allergy, food intolerance, medical condition or disability which requires a special diet, LPS Nutrition Services will accommodate that dietary request upon receipt of a completed ***Medical Statement For Students With Special Nutritional Needs*** (page 2 of this form). ***Section 2 – Diet Order*** must be completed by your licensed health care professional. A note from a physician on a prescription pad or office letterhead cannot be accepted because it does not contain all the required information or parent signature. Information required includes:

- The child's medical condition, allergy or impairment that requires a dietary modification.
- The specific dietary restrictions, modifications or instructions to treat the identified medical condition.
- Other instructions such as texture modifications or thickening of liquids to ensure the student meal can be safely consumed.

To ensure student safety, allow up to five school days from receipt of the Medical Statement for Nutrition Services to plan and obtain special foods needed for your child. During this time, please plan to send a lunch from home. If your student does not eat meals at school and will always bring lunch from home, it is still important for the school health office to be aware of all medical conditions including food allergies.

Please feel free to call or email Lynn Goering, Special Diet Dietitian at 402-436-1745 or lgoering@lps.org. The LPS website also contains a wealth of information about special diets, including Q&A's, special menus and other information: The webpage can be found at lps.org, scroll down to the "Special Diet" link or type "special diets" in the search box.

**PARENT REQUEST – PERSONAL DIETARY CHANGE:** A parent may request any of the following three dietary changes by filling out SECTION 3 of the ***Medical Statement For Students With Special Nutritional Needs*** form. The signature of your health care provider is not needed for these three requests.

(1) A Meatless Entrée
(2) Lactose-Free Milk
(3) Non-Dairy Milk Substitute

**USDA NON-DISCRIMINATION STATEMENT** In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

**mail:** U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

**or**

**fax:** (833) 256-1665 or (202) 690-7442; **or email:** Program.Intake@usda.gov

**This institution is an equal opportunity provider.**

**INSTRUCTIONS: Complete SECTION 1 – STUDENT INFORMATION.** This form may be used for the following:

1. *Special Diet Needed Due to Allergy, Intolerance, Medical Condition or Disability* – **Health Care Provider completes SECTION 2.** SECTION 2 **MUST** be completed and signed by a State Licensed Health Care Professional (Physician (MD or DO), Physician's Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor (DC). A Licensed Medical Nutrition Therapist (LMNT) may also complete and sign when acting under the consultation of a licensed physician. This section cannot be completed by the parent/guardian.
2. *Parent Request For Dietary Change For Personal Reasons* – **Parent completes and signs SECTION 3**. The parent should complete both SECTION 1 and SECTION 3 (skip Section 2) to request the following three dietary change(s): A. Meatless/Vegetarian, B. Lactose-Free Milk, C. Non-Dairy Milk Substitute. The signature of a State Licensed Health Care Provider is not needed for these three requests. Use box D. to document a peanut, tree nut allergy.

**QUESTIONS:** Please call Lincoln Public Schools, Nutrition Services Dietitian at **402-436-1745**.

**RETURN COMPLETED FORM:** To the school's Health Office or via fax to Nutrition Services **402-436-1775**.

To ensure student safety, please allow up to five school days from receipt of this form for Nutrition Services to plan menu changes and obtain the special foods needed for your student. During this time, please send a lunch from home.

## SECTION 1 – STUDENT INFORMATION

| | | | |
|---|---|---|---|
| Student Name *(First):* | *(Last):* | | Date of Birth: |
| Parent Name *(First):* | *(Last):* | | Student ID: |
| Phone: | Email: | School: | Grade: |

## SECTION 2 – SPECIAL DIET FOR ALLERGY, INTOLERANCE, MEDICAL CONDITION OR DISABILITY

**Section 2 MUST be completed and signed by a Licensed Provider (MD, DO, PA, APRN-NP, DC, LMNT). See instructions.**

A. Student's Diagnosis, Food Allergy, Intolerance or Medical Condition:

B. Dietary Restriction, Modification or Prescription OR Check all that apply:

| | | | |
|---|---|---|---|
| DAIRY/MILK: | ☐ Dairy Free Diet | ☐ Low Lactose Diet | ☐ No Cheese or Yogurt |
| MILK SUBSTITUTE: | ☐ Lactose-Free Milk | ☐ Non-Dairy Milk Substitute | |
| GLUTEN/WHEAT: | ☐ Gluten-Free Diet | | |
| TEXTURE MODIFICATIONS: | ☐ Soft | ☐ Chopped | ☐ Puree ☐ Other: |
| THICKENED LIQUIDS: | ☐ Nectar | ☐ Honey | ☐ Pudding ☐ Other: |

| | |
|---|---|
| C. Printed Name Licensed Health Care Provider: | Phone: |
| D. **Signature Health Care Provider:** | Date: |

## SECTION 3 – PARENT REQUEST – PERSONAL DIETARY CHANGE Check all that apply.

A. ☐ Meatless/Vegetarian. Or check only those that apply: ☐ No Beef ☐ No Pork ☐ No Chicken ☐ No Turkey

B. ☐ Lactose-Free Milk ☐ C. Non-Dairy Milk Substitute D. ☐ Peanut Allergy E. ☐ Tree Nut Allergy

| | |
|---|---|
| F. **Signature Parent/Guardian:** | Date: |

I give permission for the school to follow the above diet and agree to allow the school to share information on a "need-to-know" basis with their employees in order to accommodate meals and food-related activities. I agree to allow my child's health care provider and school personnel to discuss information on this form.

**OFFICE USE** Date Received: _____ ☐ Synergy ☐ NS Computer

☐ Emailed ☐ FAXED ☐ Copy To: ☐ Health Office ☐ LPSDO ☐ Cafeteria Initials: _____