Medical Statement for Students with Special Nutritional Needs for School Meals
New Hanover County Schools

Send a copy of the completed form to: Stephanie Hull, Child Nutrition Department,1802 South 15th Street, Wilmington, N.C. 28403
stephanie.hull@nhcs.net Fax: 910-254-4178/ Phone: 910-254-4296

Part A (To be completed by Parent/Guardian)

Name of Student: (Last) _____ (First) _____ (Middle) ____

Student ID # _____ School _____ Grade _____

Will student eat breakfast from cafeteria? ☐ Yes ☐ No

Will student eat lunch from cafeteria? ☐ Yes ☐ No

Will the student eat snack in the after school snack program? ☐ Yes ☐ No

Name of Parent/Guardian: _____

Mailing Address: _____ City: _____ State/Zip: _____

Phone number(s): _____ (Work) _____ (Home) _____ (Cell)

What concerns do you have about your student's nutritional needs at school or your student's ability to safely participate in mealtime at school?

Does the student have an identified disability (IEP or 504 Plan)? ☐ Yes ☐ No

If *Yes* and you have concerns about nutritional needs, have a licensed physician complete Part B of this form and sign it. Return completed form to contact at the top of this page.

If *No* and you have concerns about nutritional needs, have a licensed physician or recognized medical authority complete Part B of this form and sign it. Return completed form to contact at the top of this page. Special dietary needs for students without IEP or 504 plans are accommodated at the discretion of the Child Nutrition Administrator and policies of the school district.

signature of parent/guardian	printed name	telephone number	Date

Part B Diet Order (To be completed by Licensed Physician)

Student Diagnosis or condition:	Describe major life activities affected:

Specify any dietary restrictions or special diet instructions for school meals:

List any foods causing food allergies or intolerances that should be avoided:

If student has life threatening allergies, check appropriate box(es): ☐ ingestion ☐ contact ☐ inhalation

Designate consistency requirements for food:

☐ Clear Liquid ☐ Pureed
☐ Full Liquid ☐ Mechanical Soft
☐ Blenderized Liquid

Designate consistency requirement for liquids:

☐ Thin ☐ Honey-like
☐ Nectar-like ☐ Spoon-thick

For any special diet, list specific foods to be omitted and suggested substitutions; You may attach a separate page with additional information.

a. Foods To Be Omitted	b. Suggested Substitutions

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

signature of physician/medical authority*	printed name	telephone number	date

* A licensed physician's signature is required for students with a disability. For students without a disability, a licensed physician or medical authority must sign the form.

Part C (To be completed by Child Nutrition Services)

Child Nutrition Services Notes:

CN Administrator Signature: _____ **Date:** _____