South Tippah School District

Child Nutrition Program

402 Greenlee Avenue Ripley, MS 38663 · Phone 662-837-8779 · Fax 662-837-1362

Special Accommodations with School Meal Programs

School Year **2024/2025.** This document is in effect until medical authority revises special diet. Please fax completed form to 662-837-1362.

Student's Name: _____ Age:_____ DOB:_____ Student #_____

School: _____ Grade:_____ Homeroom: _____

Parent's Name: _____Parent's E-mail_____

Address:_____ Telephone: _____

_____
(Street or P.O. Box) City Zip

1. Does the child have a disability or IEP/IAP on file? Yes or No If yes, describe the major life activities affected by the disability. _____
2. If the child is not disabled does the child have special nutritional or feeding needs? Yes or No _____
3. Does your child have an Epi-Pen for specific food or foods? Yes or No If yes, please list food or foods._____

List Disability/Medical Condition_____

Diet Prescription (check all that apply):

		Carbohydrate Grams	*Carbohydrate Grams*
€	Diabetic: Carbohydrate Counting OR	_____Breakfast	_____AM Snack
€	Lactose Intolerance (eliminate fluid milk):	_____Lunch	_____PM Snack
	Other dairy allowed: cooked cheese, etc.	_____Yes	_____No
	Please document substitute for Fluid Milk:	_____Juice	_____Water
€	Calorie Count: _____Breakfast Calories	_____Lunch Calories	_____AM/PM Snack
€	Calories		
€	Texture Modification: _____Diced	_____Chopped	_____Ground
€	_____Pureed (check one): ☐ Milk-like ☐ Nectar-like ☐ Honey-like ☐ Pudding-like		

Other Diet Prescription:_____

Religious Reason:_____

FOOD INTOLERANCE
(Diarrhea, Bloating, Headaches, Nausea, Rashes)

Level I – eliminate intolerable food only

- € Milk (fluid form only) – cheese allowed
  Substitute: ☐ Juice ☐ Water
- € Milk and Dairy Products
- € Eggs
- € Wheat
- € Soy
- € Other:_____

FOOD ALLERGY

(Will omit ALL foods that contain any of these items checked)
Level II – eliminate products with food allergen

☐ Milk	☐ history of inhalation reaction
☐ Eggs	☐ history of inhalation reaction
☐ Fish	☐ history of inhalation reaction
☐ Shellfish	☐ history of inhalation reaction
☐ Tree Nuts	☐ history of inhalation reaction
☐ Peanuts	☐ history of inhalation reaction
☐ Wheat	☐ history of inhalation reaction
☐ Soy	☐ history of inhalation reaction
☐ Other:_____	

I certify that the student named above needs special diet accommodations prepared as described related to the student's medical condition.

Office Address: _____ Office Telephone:_____

_____ Office Fax: _____

_____ Date_____

Licensed Physician/Recognized Medical Authority Signature ****SIGNATURE REQUIRED TO PROCESS****

Guidelines and Requirements For
Special Accommodations with School Meal Programs

These guidelines and requirements have been established to ensure the safety of students when medically necessary menu change must be implemented.

- Per USDA, a new diet prescription form MUST be completed annually regardless if any changes occur.
- Diet prescription forms must be filled out completely.
- Diet prescription form MUST be signed by a Physician or recognized Medical Authority.
- Diet Prescription forms will not be altered unless the Diet Prescription Form is updated by the physician.
- Diabetic Meal Plans: include the number of carbohydrates for each meal and snack.
- Food Allergens: include specific information regarding foods to omit and substitute.
- If the student cannot have fluid milk, please document appropriate substitute. We can provide bottled water, or a 4oz juice, as a substitution.
- Diet restrictions due to religious beliefs- parent/guardian MUST complete the current year Diet Prescription Form stating the specific food to eliminate.
- Diet Prescription Forms MUST be completed before implemented at the school site.
- Menu substitutions will be provided at the discretion of the Child Nutrition Services Office according to current food availability.
- Please allow 5 days for processing in the Central Office. Parent/Guardian will need to provide breakfast and/or lunch during this time. Please fax, mail or deliver the form to the South Tippah Child Nutrition Department, 402 Greenlee Avenue Ripley, MS 38663, Phone # (662-837-8779) Fax # (662-837-1362).
- If the student has a Food Intolerance **(digestive system response)** – Level I, Check the foods that apply. The indicated allergen foods will be eliminated from the student's meal tray if its whole form. (Example: The student has an intolerance to eggs, the student will not be served whole eggs such as scrambled eggs, hard boiled eggs, etc.)
- If the student has Food Allergy **(immune system response)** – Level II, check the foods that apply. The indicated allergen foods will be eliminated from the student's meal tray in its whole form as well as any food that contains the allergen food as an ingredient. (Example: The student has an allergy to eggs, the ingredient listing will be reviewed for eggs and any foods containing eggs will be eliminated from the student's meal tray). Please indicate if the student has a history of inhalation induced anaphylaxis reaction to the specified allergen.
- Confirmation of process completion will be sent to parent/guardian via contact number/email provided.

FOR INTERNAL USE ONLY

APPROVED: ☐

DENIED: ☐

REASON FOR DENIAL: _____

_____

Non Discrimination Statement : This explains what to do if you believe you have been treated unfairly.

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