ROANOKE CITY PUBLIC SCHOOLS STATEMENT FOR STUDENTS WITH SPECIAL DIETARY NEEDS

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| Students' Name: | | Date of Birth : | ID# |
| School: | | Grade: | Teacher: |
| Does student have IEP or a 504 Plan ? YES **NO** | | | |
| Will student eat breakfast at school? YES NO  Will st udent eat lunch at school? YES **NO** | | | |
| **PART A: STUDENTS WITH SPECIAL DIETARY NEEDS BASED ON PHILOSOPHICAL/RELIGIOUS BELIEFS OR**  **MEDICALLY-UNDIAGNOSED CONDITIONS NOTE: Medical Provider signature is not required** | | | |
| List any dietary restrictions or special diet including comment s about child's eating or feeding patterns. | | | |
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| **Parents please note:**  Food substitutions for Special dietary needs based on religious/philosophical beliefs or medically undiagnosed conditions are NOT required to be provided for students without a documented disability or a medically documented condition requiring dietary modification. Provisions for such students include only dietary omissions that fall under Offer vs Share. The food service staff will also be responsible for alerting individual students of menu items intended for purchase that contain the foods or ingredients our POS system has identified as a restriction for that child. The individual student ultimately will make the decision whether or not to take the item(s) after being alerted of the content. A new form for this type of dietary preference will not be needed each year. The information will remain in the RCPS Dietary system. To remove previous restriction, a written/signed parent request must be submitted to the school nurse or cafeteria manager at any time during the school year. | | | |
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| **PART B: STUDENTS WITH MEDICALLY DIAGNOSED SPECIAL DIETARY NEEDS**  **NOTE: A FOOD ALLERGY ACTION PLAN, signed by a medical provider is required for students with life-threatening food allergies** | | | |
| List diagnosis or medical condition | | | |
| Specify any dietary restrictions or special diet instructions for school meals | | | |
| List any special equipment or utensils that are needed | | | |
| List foods that need the following change in texture: If all foods need to be prepared in this manner, indicate "ALL".  *Cut up or chopped into bite-size pieces: Finely ground:*  *Pureed:* | | | |
| Provide any additional information about your child' s dietary needs/eating habits: | | | |
| **Parent Name** | **Parent signature** | | |
| **Parent daytime phone** | **Date:** | | |
| **Health Care Provider Name** | **Signature Date:** | | |
| School Nurse signature | Date: | | |
| To Cafe Mgr: HCP signature pending | To Cafe Mgr: HCP Signature | | |
| **OFFICE USE ONLY** | | | |
| Received by: | Date: Initials: | | |
| Fax received at Food Service Office : | Date: Initials | | |
| Added to student account: | Date: Init ials: | | |

Revised 4/15; 7/15 ;8/16