Medical Statement for Students with Allergies or Students Requiring Special Meals/Substitutions
Food Services Department Neosho R-5 School District

Mail to: Food Services 418 Fairground Road, Neosho, MO 64850 or Fax to: 417-451-8601

This statement **MUST** be updated when there is a change in the diet order.

Name of Student:_____ **Student's Birth Date:**_____
Parent Name:_____ **School Grade:**_____
Parent Name: Telephone:_____ **School Attended:**_____
Physician's Name (Please Print):_____

I hereby give my permission for the school staff to follow the stated nutrition plan below. I give my permission for the nutrition services to contact the above Physician if questions arise. *This must be signed by the parent/guardian,* ***no exceptions***.

_____ _____
Parent/Guardian Signature **Date**

For Physician's Use: (to be completed by a licensed medical physician). This section must be filled out**, no exceptions.**

Identify and describe the disability, or medical condition, including allergies that require the student to have a special diet or items eliminated from the diet.

_____

_____

Describe the major life activities affected by the student's disability (see back of form or attached for USDA definition). _____

_____

Diet Prescription (check all that apply):

☐ Diabetic (include calorie level or attach meal plan)
☐ Modified Texture and/or Liquids
☐ Calorie Controlled:_____ calorie level
☐ Other (describe):_____
☐ Food Allergy (Please list each allergy):_____

***Please be specific, if the student has a milk allergy is it fluid milk only or all milk product. If the student has an egg allergy, is it just fresh eggs or are eggs baked/cooked in products ok.

If student has a food allergy, is this a life-threatening allergy? ☐ **Yes** ☐ **NO**

Food Omitted and Substitutions:
If foods are listed to be omitted from the diet, **specifies** on foods to substitute **must** be provided. An additional sheet may be attached if necessary.

Foods to Omit	**Foods to Substitute**

Indicate Texture:
☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Indicate thickness of liquids:
☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ **Special Feeding Equipment**_____

Additional comments:_____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition. *The state of Missouri requires the signature of a licensed medical physician*.

Licensed Physician's Signature	**Phone Number- Fax Number**	**Date**
Signature of Preparer or Other Contact	**Phone Number- Fax Number**	**Date**

"Handicapped person" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has record of such an impairment, or is regarded as having such an impairment.
"Physical or mental impairment" means (1) any physiological disorder or condition, cosmetic disfiguration, or anatomical loss affecting one or more of the following body systems:
Neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic skin, and endocrine or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction, and alcoholism.

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.