Northwest Classical Academy
Medical Statement & Diet Prescription for Meals at Schools

This form is for students who are and are not defined as "handicapped." A 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 impairments, or is regarded as having such impairments (7 CFR Part 15b and FNS Instruction 783-2). All sections of the form will need to be completed by a licensed physician if the student is diagnosed with a "handicap" per Federal law 7 CFR Part 15b and FNS Instruction 783-2 or one of the following medical authorities: physician, &/or physician assistant, nurse practitioner, registered/licensed dietitian if the student is not "handicapped," but is unable to consume food(s) because of medical or other special dietary needs. The first section ("Describe the student's handicap and the major life activity(s) affected by it") does not have to be completed by the appropriate medical authority when a student is not diagnosed "handicapped".

Student's Name: _____ DOB: _____ Ht: _____ ☐ inches ☐ cm Wt: _____ ☐ lbs ☐ kg

School: _____ Grade/Teacher: _____

Diagnosis: _____

Describe the student's *"handicap"* and the major life activities affected by it: _____

_____

Please list any dietary restrictions or special diet: _____

_____

Please list any allergies or food intolerances to avoid. Please indicate the child's *reaction* to this food. _____

_____

Please list the food(s) that may be substituted in the diet: _____

_____

Physician recommended diet:

_____Nothing by mouth (NPO) ***Prescription provided to family for formula supplement / Formula provided for school feeds by parent. Initial:_____**

_____By mouth (PO) Type Diet: Regular ( ) Chopped ( ) Pureed ( )

Liquids:

Regular_____Thickened_____ / Thickened Consistency: Nectar_____Honey_____Pudding_____

_____ Formula Supplement to school meal (**ORAL ONLY**)
_____ Formula G-Tube Feed
Name of Formula_____ (Substitute allowed? Yes / No)
Amount at each feeding_____
Time(s) to be fed_____
Amount of water_____CC
Amount of water to flush_____CC

Type of G-Tube Feeding: Bolus_____ Slow Drip_____ Pump_____ / Pump Setting: _____

Swallow study done? Yes No **CIRCLE ONE** (If yes, please attach if available and indicate Date:_____/_____/_____)

Other information regarding the diet: _____

_____ _____ _____
Signature of the M.D. or Authorized Medical Authority **Date** **Telephone #**

_____
Address of the Medical Office

_____ _____ _____
Parent's Signature (*Initial formula line above) **Date** **Telephone #**

(REVISED 02/2013)