Return completed form to:
Nutrition Services Center
360 Farmington Avenue Louisville, KY 40209
nutritionspecialdiets@jefferson.kyschools.us
Fax: 502.485.6494

JEFFERSON COUNTY PUBLIC SCHOOLS
SCHOOL HEALTH PLAN
SPECIAL DIETARY NEEDS

Please print neatly. Por favor, escriba legible

School Year:

DO NOT WRITE IN THIS AREA
5500483184

PART A Parent / Guardian: Complete Items 1 - 15 *(Padre/madre/tutor: complete la información en los espacios 1 al 15)*

1) Student ID# *(Numero de estudiante)* | **2) Student's Last Name** *(Apellido)* | **3) Student's First Name** *(Nombre del estudiante)* | **4) Date of Birth** *(Fecha de nacimiento)*

5) School *(Escuela)* | **6) Grade** *(Grado)*

7) Meals Eaten at School *(Los alimentos que su niño(a) consumirá en la escuela)*
☐ **Breakfast** *(Desayuno)* ☐ **Lunch** *(Almuerzo)* ☐ **Snack** *(Meriendao)* ☐ **None** *(Nada)*

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

8) Name *(Nombre)* | **9)** Phone Number *(Teléfono)* | **10)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

11) E-mail Address (We will use this to send acknowledgement and details of your child´s menú plan. PRINT NEATLY)
Dirección electrónica (será usada para acuso de recibo y detalles sobre el menú de su niño. IMPRIMA)

12) Parent Requests that are not due to a medical disability. Please Note: Nutrition Services may attempt to accommodate cultural/personal preferences but are not required by law to do so. These accommodations depend on product availability on the daily serving line. ☐ **Vegan** ☐ **Vegetarian** ☐ **No Pork** ☐ **No Beef** ☐ **Other**

13) Does the student have an identified disability (IEP or 504 Plan)? *¿Ha sido el estudiante identificado con una discapacidad (PEI o Plan 504)?* ☐ IEP ☐ 504 ☐ No

14) I consent to the exchange of information between the Healthcare Provider and district/school personnel, as needed.
(Doy mi consentimiento para que la información sea intercambiada entre el médico y la escuela, según sea necesario)

Parent / Guardian Signature (required for processing) ***(Firma del padre/madre/tutor*** *- requerido para ser procesado)* X _____ **Date** *(Fecha)* _____

15) Parent/Guardian: It is REQUIRED that this completed form is returned to JCPS Nutrition Services. All further changes to the child's diet must be made by a State licensed healthcare professional on a new form with the exception of cultural/personal preferences.
Parents please note: A prescription authorization form must be on file at school for medications to be given at school.
(Padre/madre/tutor: Se REQUIERE que se devuelva la forma debidamente completada al gerente de la cafetería. Cualquier cambio en la dieta del estudiante debe ser hecho por un médico en una nueva forma, a excepción de la intolerancia a lactosa o preferencias culturales.
Nota a los Padres: Un formulario de autorización de receta debe estar archivado en la escuela para que los medicamentos puedan ser administrados en la escuela.*)*

*Information regarding major allergens and nutrient/carbohydrate information are available for review at http://jcps.nutrislice.com
(Ver información sobre alergenos y nutrientes/carbohidratos en http://jcps.nutrislice.com)

PART B COMPLETED BY HEALTHCARE PROVIDER (MD, APRN, PA, OD) ONLY: Complete Items 16 – 21
(16 al 21 - Esta sección para ser completada por el médico solamente.)

16) Does the student have a disability, medical condition, or severe food allergy warranting a special diet? ☐ **Yes** ☐ **No**
If "YES", specify disability below. If "no", a special diet is not warranted. A disability is defined as a physical or mental impairment which substantially limits one or more major life activities.

Disability (specify) _____

Describe major life activities affected ☐ **Eating** ☐ **Learning** ☐ **Digestion** ☐ **Other (specify)** _____

Student Diagnosis or Condition:
☐ Lactose Intolerance: Available options to substitute are: ☐ Lactose Free Milk ☐ Soy Milk
Mark if the student can eat: ☐ Cheese ☐ Yogurt

For the following diagnosis, section 17 below must be completed to identify which foods must be omitted due to the identified condition:
☐ Food Intolerance ☐ Food Allergy ☐ Life Threatening Food Allergy

17) Please check all food(s) to omit from the child's meals while at school due to the above noted disability:

DAIRY Anaphylactic ☐ Yes ☐ No
- ☐ All food/beverages with milk listed as an ingredient including baked goods
- ☐ Cheese and recipes with cheese listed as an ingredient
- ☐ Yogurt
- ☐ Fluid Milk. Substitute with ☐ Lactose-free milk ☐ soy milk ☐ water

EGG Anaphylactic ☐ Yes ☐ No
- ☐ Whole eggs such as scrambled eggs or hard cooked eggs
- ☐ All food items with egg listed as an ingredient including baked goods

WHEAT / GLUTEN Anaphylactic ☐ Yes ☐ No
- ☐ Recipes with wheat listed as an ingredient
- ☐ Recipes with Gluten (wheat, barley, rye, triticale) listed as an ingredient

PEANUTS OR TREE NUTS Anaphylactic ☐ Yes ☐ No
- ☐ Peanuts ☐ Tree Nuts

CORN Anaphylactic ☐ Yes ☐ No
- ☐ Whole corn such as corn kernels, tortilla chips, corn muffin
- ☐ Recipes with corn listed as an ingredient (corn syrup, corn starch, etc.)

SOY Anaphylactic ☐ Yes ☐ No
- ☐ Recipes with any soy listed as an ingredient

FISH OR SHELLFISH Anaphylactic ☐ Yes ☐ No
- ☐ Fish ☐ Shellfish

OTHER Anaphylactic ☐ Yes ☐ No
- ☐ Other, specify if it is a cooked ingredient or when consumed fresh

18) May student carry own EpiPen/Auvi-Q device and use on their own? ☐ Yes ☐ No

19) Food Texture Modifications:
Is student allowed to have any food/drink by mouth? ☐ Yes ☐ No
Food Texture Modifications that are required due to the noted disability in section #16: ☐ Pureed ☐ Mechanically/Finely Ground ☐ Cut up/Chopped into bite sized pieces
Thickened liquids: ☐ None ☐ Honey ☐ Nectar

20) Other Nutrition Requirements due to documented disability in Section #16: Please specify:

21) Healthcare Provider Information ***Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.***

Healthcare Provider Signature X _____ Date _____

Healthcare Provider Printed Name _____

Medical Office Stamp (required for processing)