



**Atlanta Public Schools  
School Nutrition Department  
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 #