NS0002
Rev. 4/26

MEDICAL STATEMENT FOR STUDENTS WITH SPECIAL NUTRITIONAL NEEDS

Nutrition Services Department
(402) 436-1745 • Fax (402) 436-1775
Lincoln Public Schools • Lincoln, Nebraska

Dear Parent or Guardian,

SPECIAL DIETS FOR ALLERGIES AND MEDICAL CONDITIONS: If your student has a diagnosed food allergy, food intolerance, medical condition or disability which requires a special diet, LPS Nutrition Services will accommodate that dietary request upon receipt of a completed *Medical Statement For Students With Special Nutritional Needs* (page 2 of this form). *Section 2 – Diet Order* must be completed by your licensed health care professional. A note from a physician on a prescription pad or office letterhead cannot be accepted because it does not contain all the required information or parent signature. Information required includes:

- The child's medical condition, allergy or impairment that requires a dietary modification.
- The specific dietary restrictions, modifications or instructions to treat the identified medical condition.
- Other instructions such as texture modifications or thickening of liquids to ensure the student meal can be safely consumed.

If your student attends preschool, meals are served in the classroom so it is important to return the completed form before their start date. For school age children, allow up to five school days from receipt of the Medical Statement for Nutrition Services to plan and obtain special foods needed for your child. During this time, please plan to send a lunch from home. If your student does not eat meals at school and will always bring lunch from home, it is still important for the school health office to be aware of all medical conditions including food allergies.

Please feel free to call or email the Special Diet Dietitian at 402-436-1745 or specialdiets@lps.org. The LPS website also contains a wealth of information about special diets, including Q&A's, special menus and other information: The webpage can be found at lps.org, scroll down to the "Special Diet" link or type "special diets" in the search box.

PERSONAL DIETARY REQUESTS – PARENT REQUEST: A parent may request any of the following three dietary changes by filling out SECTION 3 of the *Medical Statement For Students With Special Nutritional Needs* form. The signature of your health care provider is not needed for these three requests.

1. A Meatless Entrée
2. Lactose-Free Milk
3. Non-Dairy Milk Substitute

USDA NON-DISCRIMINATION STATEMENT In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender. *Rev03/2025*

INSTRUCTIONS:

SECTION 1 S*tudent Information* – This section may be completed by the parent and/or Health Care Provider

SECTION 2 S*pecial Diet For Allergy, Intolerance, Medical Condition or Disability* – **State Licensed Health Care Provider completes and signs this section.** Section 2 **MUST** be completed by a State Licensed Health Care Professional (Physician (MD or DO), Physician's Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor (DC), or Registered Dietitian (RDN). This section **CANNOT** be completed by the parent/guardian.

SECTION 3 *Personal Dietary Request – Parent Request* – **Parent completes and signs this section.** The parent should complete both SECTION 1 and SECTION 3 (skip Section 2) to request the following three dietary change(s): A. Meatless/ Vegetarian, B. Lactose-Free Milk, C. Non-Dairy Milk Substitute. Use box D. to document a peanut, tree nut allergy.

RETURN FORM:	**VIA EMAIL: specialdiets@lps.org**	**VIA FAX: 402-436-1775**

Or drop off at your school's Health Office. If your student attends preschool, meals are served in the classroom so it is important to return the completed form before their start date. For school age children, allow up to five school days from receipt of the Medical Statement for Nutrition Services to plan and order special foods needed for your child. During this time, please plan to send a lunch from home.

QUESTIONS: Please call the Special Diet Dietitian at 402-436-1745.

SECTION 1 – STUDENT INFORMATION *Section 1 may be completed by Health Care Provider or Parent.*			
Student Name *(First):*	*(Last):*		Date of Birth:
Parent Name *(First):*	*(Last):*		Student ID:
Phone:	Email:	School:	Grade:

SECTION 2 – SPECIAL DIET FOR ALLERGY, INTOLERANCE, MEDICAL CONDITION OR DISABILITY

Section 2 ***MUST*** *be completed and signed by a Licensed Provider (MD, DO, PA, APRN-NP, DC, LMNT). See instructions.*

A. Student's Diagnosis, Food Allergy, Intolerance or Medical Condition:

B. Student's Dietary Restriction, Modification or Prescription OR Check all that apply:

DAIRY/MILK:	❑ Dairy Free Diet	❑ Low Lactose Diet	❑ No Cheese or Yogurt
MILK SUBSTITUTE:	❑ Lactose-Free Milk	❑ Non-Dairy Milk Substitute	
GLUTEN/WHEAT:	❑ Gluten-Free Diet		
TEXTURE MODIFICATIONS:	❑ Soft	❑ Chopped	❑ Puree ❑ Other:
THICKENED LIQUIDS:	❑ Nectar	❑ Honey	❑ Pudding ❑ Other:

C. Printed Name Licensed Health Care Provider:	Phone:
D. **Signature Health Care Provider:**	Date:

SECTION 3 – PERSONAL DIETARY REQUEST & PARENT SIGNATURE Check all that apply.

A. ❑ Meatless/Vegetarian Or check only those that apply: ❑ No Beef ❑ No Pork ❑ No Chicken ❑ No Turkey

B. ❑ Lactose-Free Milk C. ❑ Non-Dairy Milk Substitute D. ❑ Peanut Allergy E. ❑ Tree Nut Allergy

F. **Signature Parent/Guardian:**	Date:

I give permission for the school to follow the above diet and agree to allow the school to share information on a "need-to-know" basis with their employees in order to accommodate meals and food-related activities. I agree to allow my child's health care provider and school personnel to discuss information on this form.

OFFICE USE Date Received: _____ ❑ Synergy ❑ NS Computer ❑ Labels

❑ Emailed ❑ FAXED ❑ Copy To: ❑ Health Office ❑ LPSDO ❑ Cafeteria Initials: _____