



You and I ... We are
ST. CHARLES PARISH PUBLIC SCHOOLS

Date: _____

Dear Parent of _____

Meal service to students with special dietary needs is provided to all school sites. Federal and State regulations require a completed and current diet prescription form for any type of change or substitution to the student's diet.

The special diet prescription form will need to be completed by your child's physician and returned to the school nurse. We will not process a special diet request for your child until we receive the 2019-2020 form. The form is available from the school nurse or you can download it from the <http://www.stcharles.k12.la.us/departments.cfm?subpage=48276>.

If a student cannot have fluid milk due to a medical diagnosis, the Physician must prescribe the milk substitute on the Diet Prescription Form. In cases where there is no diagnosis on file, students will not be provided with a substitute beverage as part of the meal. However, water or juice will be available for purchase in the school's cafeteria.

Should you have any questions please call the school's nurse or Child Nutrition Department at 985-785-3179.

Sincerely,
Teresa C. Brown MS, RD, LDN
Director of Child Nutrition
St. Charles Parish Public Schools

USDA Nondiscrimination 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, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

13855 River Road
Luling, LA 70070
985.785.6289
www.stcharles.k12.la.us

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St. Charles Parish Public Schools
 Child Nutrition Programs
 Diet Prescription Form
 2019-2020

Student's Name: _____ Age: _____ DOB: _____ Student # _____

School: _____ Grade: _____ Homeroom: _____

Parent's Name: _____ Parent's E-mail _____

Address: _____ Telephone: _____
 (Street or P.O. Box) City Zip

1. Does the child have a disability? Yes or No If yes, describe the major life activities affected by the disability.

2. If the child is not disabled does the child have special nutritional or feeding needs? Yes or No

3. Does your child have an Epi-Pen for specific food or foods? Yes or No If yes, please list food or foods.

Please complete section below:

Medical Condition: _____

Diet Prescription: _____

(mark all that apply):

Food Intolerance (digestive System Response)

- Lactose Intolerance: Eliminate Fluid Milk Only
 Substitute (circle) Water, Juice, Soy, Lactaid or other
 Other Milk products to omit: _____
 Soy
 Wheat
 Wheat (due to celiac Disease)
 Other _____

Food Allergy (Immune system response)

- Eggs
 Fish
 Milk
 Tree Nuts
 Peanuts
 Shellfish
 Soy
 Other: _____

Texture modification (circle one) Chopped Ground Pureed Liquefied

Diabetic Diets "Carbohydrate Distribution" = Breakfast _____ Lunch _____ Snack _____ (# of Carbs/meal)

Any Other Specific Dietary Need: _____

Specific Foods to Omit

Specific Foods to Substitute

Specific Foods to Omit	Specific Foods to Substitute

I certify that the above named student needs special meals prepared as described above because of the student's chronic medical condition.

Office Address: _____ Office Telephone: _____
 _____ Office Fax: _____

Date _____

Licensed Physician/Recognized Medical Authority Signature

Definition of Disability

Definitions

As used in this part, the term or phrase:

(i) *Student with disabilities* means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(j) *Physical or mental impairment* means (1) any physiological disorder or condition, cosmetic disfigurement, 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; and drug addiction and alcoholism.

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

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