Diet Modification Request for Foods Served Through Child Nutrition Programs of Grinnell-Newburg Community School District

Student's Name: ______________________________ Birth date: ______________
District and/or school/site: ____
Parent/Guardian Name: ________________________ Phone: ________________

Does the patient have a disability as defined in Section 504 of the Rehabilitation Act of 1973 of the Americans with Disability Act and updates?

☐ **YES = Disability-To be completed by licensed physician** (In Iowa this includes: M.D., D.O., or Chiropractor)

Federal regulations governing the Child Nutrition Programs provide that schools/districts **must** make substitutions in meals for students who are considered to have a disability as defined by the Americans with Disability Act and whose disability restricts their diet when supported by a statement signed by a physician licensed by the state which includes all information in questions a and b below.

a. **Must** identify: 1) the impairment/diagnosis that is a disability, 2) the major life activity affected, and 3) why it alters the student's diet:

b. What diet modifications are needed? (e.g., texture changes and/or food item substitutions)

Must identify any foods to be omitted: **(see back of page)**	**Must** identify foods to be substituted/added

Signature of Licensed Physician: ______________________________ Date: __________
Please print name: ____

☐ **NO = Medical condition, but not a disability – To be completed by recognized medical authority**

A school/district, **at its discretion**, may make menu substitutions with a signed statement from a medical authority for a student who is not disabled but is unable to consume food items because of food intolerances or allergies.

a. Please identify the medical or other special dietary condition including intolerances and allergies that alters the student's diet:

b. What diet modifications are requested? (e.g., texture changes and/or food item substitutions)

List any foods to be omitted: **(see back of page)**	Foods to be substituted/added

Signature of Medical Authority: ______________________________ Date: __________
Please print name: ____

Questions? Please contact Carrie Nachazel at 641-236-2668 or carrie.nachazel@grinnell-k12.org
Please return this form to the school Nurse or office to be forwarded to the Food Service Department.

To be kept on file in the Child Nutrition Services Office.
Date received by Child Nutrition: ___________ Date discontinued: ___________(Attach documentation)

Some common allergens with various ways they are found in foods.
Please check the box in front of food groups that should NOT be served:

Lactose/milk – *Do not serve the following checked items:*

- Fluid Milk to drink or use on cereal
- Milk based desserts such as: ice cream and pudding
- Hot entrees with cheese as a prime ingredient such as: grilled cheese, cheese pizza, or macaroni & cheese
- Cheese baked in products such as: a casserole or on meat pizza
- Cold cheese such as: string cheese or sliced cheese on a sandwich
- Milk in products such as: breads, mashed potatoes, cookies or graham crackers

SERVE THESE ITEMS INSTEAD:

¼ cup of fluid milk to be used on cereal? __yes __no

Soy - *Do not serve the following checked items*:

- Protein products extended with soy
- Processed items cooked in soy oil
- Food products with soy as an ingredient no matter where on the ingredient list
- Food products with soy listed as the fourth ingredient or further down the list

SERVE THESE ITEMS INSTEAD:

Egg - *Do not serve the following checked items:*

- Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold
- Eggs used in breading or coating of products
- Baked products with eggs such as breads or desserts

SERVE THESE ITEMS INSTEAD:

Shellfish or fish – *Do not serve the following checked items:*

- Specific fish or seafood type:________________

SERVE THESE ITEMS INSTEAD:

Peanuts – *Do not serve the following checked items:*

- Peanuts, individually or as an ingredient
- Foods containing peanut oil
- Foods items identified as manufactured in a plant that also handles peanuts

SERVE THESE ITEMS INSTEAD:.

Tree nuts – *Do not serve the following checked items:*

- Specify type(s):________________________
- Foods items identified as manufactured in a plant that also handles nuts

SERVE THESE ITEMS INSTEAD:.

Milk substitution for non-disability reasons (For a disability, the licensed physician must sign on front)

A school/district, **at its discretion**, may make **a nutrient equal substitution** with a signed statement from a parent or medical provider for a student who is unable to consume fluid milk for any reasonable request that does not rise to a level of a disability.

________ I request a substitute for fluid milk for my student.

Parent signature:______________________________ Date:______________

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call 1(866)632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact the USDA through the Federal Relay Service at 1(800)877-8339 or 1(800845-6136 (Spanish). USDA is an equal opportunity provider and employer.

It is the policy of this CNP provider not to discriminate on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, disability, or religion in its programs, activities, or employment practices as required by the Iowa Code section 216.7 and 216.9. If you have questions or

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENTS

______________________________ ___/___/___ ______________ ___/___/___
Student's Name (Last), (First), (Middle) Birthday School Date

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization by the prescriber to administer medication and/or provide the health service.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.
- Medications will be stored with the nurse/administration unless otherwise instructed by the prescriber.

______________________ ____________ ____________ ____________
Medication/Health Care Dosage Route Time at School

____

____

____
Administration instructions

____

____

____
Special Directives, Signs to Observe and Side Effects

_____/_____/_____
Discontinue/Re-Evaluate/Follow-up Date

__________________________ _____/_____/_____
Prescriber's Signature Date

__________________________ ______________________
Prescriber's Address Emergency Phone

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENTS

I request the above names student take their medication at school and school activities according to the prescription instructions above with a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment. Controlled medications must be delivered/picked up by a parent.

______________________ ____/____/____
Parent's Signature Date

______________________ ______________________
Parent's Address Home Phone

______________________ ______________________
Additional Information Business Phone

____

____

____
Authorization Form

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by IOWA CODE § 280.16.

AUTHORIZATION FOR ASTHMA OR AIRWAY CONSTRICTING MEDICATION

SELF-ADMINISTRATION CONSENT FORM

______________________ ___/___/___ ______________________ ___/___/___

Student's Name (Last), (First) (Middle) Birthday School Date

In order for a student to self-administer medication for asthma or any airway constricting condition:

- Parent/guardian provides signed, dated authorization for student medication self-administration.
- Physician (person licensed under chapter 148, 150, or 150A, physician, physician's assistant, advanced registered nurse practitioner, or other person licensed or registered to distribute or dispense a prescription drug or device in the course of professional practice in Iowa in accordance with section 147.107, or a person licensed by another state in a health field in which, under Iowa law, licensees in this state may legally prescribe drugs) provides written authorization containing:
  - o purpose of the medication,
  - o prescribed dosage,
  - o times, or;
  - o special circumstances under which the medication is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container containing the student name, name of the medication, directions for use, and date.
- Authorization is renewed annually. If any changes occur in the medication, dosage or time of administration, the parent is to notify school officials immediately. The authorization shall be reviewed as soon as practical.

Provided the above requirements are fulfilled, a student with asthma or other airway constricting condition may possess and use the student's medication while in school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities, such as while in before-school or after-school care on school-operated property. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by IOWA CODE § 280.16.

______________________ ________ ______________ ________

Medication Dosage Route Time

AUTHORIZATION-ASTHMA OR AIRWAY CONSTRCTING MEDICATION SELF-ADMINISTRATION CONSENT FORM

Purpose of Medication & Administration /Instructions

______________________________ ____/____/____

Special Circumstances

Discontinue/Re-Evaluate/ Follow-up Date

______________________________ ____/____/____

Prescriber's Signature

Date

______________________________ ______________

Prescriber's Address

Emergency Phone

- I request the above named student possess and self-administer asthma or other airway constricting condition medication(s) at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or assisting with a student's self-administration of medication.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree to provide the school with back-up medication approved in this form.
- Student maintains self-administration record.

______________________________ ____/____/____

Parent/Guardian Signature (agreed to above statement)

Date

______________________________ ______________

Parent/Guardian Address

Home Phone

____

Business Phone

____

____

____

Self-Administration Authorization Additional Information

RELEASE FOR OVERNIGHT TRAVEL PROCEDURE

The undersigned parent(s) or guardian(s) and student ______________________
(Name of student)

acknowledge having read the following and that we fully understand travel is an important part of the educational process.

1. The ______________________________ has scheduled a field trip to
(Name of organization)

____
(Destination)

from ________________________ to ________________________.
(Date of departure) (Date of Return)

2. The Grinnell-Newburg Community School District has granted approval for: (1) The aforementioned student to be absent from regular daily school attendance during the term of the field trip, and (2) the participation of the student in this field trip.

3. Travel by the student on this field trip could subject the student to various hazards and dangers during the course of the field trip including, but not limited to, negligent or intentional actions of third persons, transportation accidents, slips and fall accidents, etc.

4. Does your child have any allergies? Yes ______ No ______

   If Yes, Please explain: ________________________________

5. Are there other health concerns? Yes ______ No ______

   If Yes, please explain: ________________________________

6. ( ) I authorize school personnel to administer the following medication to my child while on overnight travel

   ( ) I authorize my child to administer (for non-controlled substances only) the following medication to themselves while on overnight travel

   NOTE: If either box is checked, this form must be accompanied by 507.2E1, 507.2E2, or 507.2E3.

   ____
   (Name of medication)

   ______________ ______________
   (Dosage) (Time)

RELEASE FOR OVERNIGHT TRAVEL PROCEDURE

____
(Name of medication)

____________ ____________
(Dosage) (Time)

____
(Name of medication 3)

____________ ____________
(Dosage) (Time)

I further state that I have received a copy of this notice, that I have read and understand it, that I have the parental/guardianship authority to execute this form, and that I hereby consent to the student's participation.

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for gross negligence as a result of self-administration of medication by the student as established by IOWA CODE §280.16.

____________________ ______________________________
(Date) (Parent/Guardian Signature)

____
(Student Signature)

2016-2017 Health/Emergency Information

Please review the following information and make changes if necessary.

Student's Name: Grade:

Birthdate: Building #:

Parent's Name ______________________

Address ______________________

City, State Zip ______________________

Home Phone ______________

Work Phone1 ______________ Description ______________

Work Phone2 ______________ Description ______________

Cell Phone1 ______________ Description ______________

Cell Phone2 ______________ Description ______________

Email ______________

Father's Workplace: ______________ Mother's Workplace: ______________

List two nearby people who will assume temporary care of your child if you cannot be reached. We must have two alternate working telephone numbers.

Name: ______________ Home Phone: ______________ Phone: ______________

Name: ______________ Home Phone: ______________ Phone: ______________

Doctor: ______________ Phone: ______________

List any health conditions such as heart disease, Diabetes, Asthma, Epilepsy, Allergies, or chronic conditions.

None ☐ Yes ☐ List: ______________

Current Medications (list all medications taken at home or school): ______________

____

Allow to administer (please check): Tylenol ☐ Antacids ☐ Cough Drops ☐

I, the undersigned, do hereby authorize officials of Grinnell-Newburg School District to contact directly the person named on this sheet, and do authorize the named physician to render such treatment as may be deemed necessary in an emergency. If the parents or other persons on this sheet cannot be reached, the school officials are authorized to act in their best judgment, for the health of the child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

I hereby release the Grinnell-Newburg School District and its designated representatives from any liability concerning the giving or non-giving of the non-prescription medication to the student.

______________________ ______________

Signature of Parent/Guardian Date

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF NON-PRESCRIPTION MEDICATION TO STUDENTS

The undersigned are the parent(s), guardian(s), or person(s) in charge of

______________________	__/__/__	____________	__/__/__
Student's Name (Last), (First), (Middle)	Birthday	School	Date

We (I) hereby request the Grinnell-Newburg School District, or its authorized representative, to temporarily or periodically administer non-prescription medication to the student named above.

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization by the parent to administer medication and/or provide the health service.
- The medication is in the original manufacturer's labeled container.
- The medication is personally given to the nurse or principal.
- Medications will be stored with the nurse/administration.
- The student requests the medication each time.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

______________________	__________	__________	__________
Medication	Dosage	Route	Time at School

____
Administration instructions

____/____/____
Discontinue/Re-Evaluate/Follow-up Date

______________________	__________	__________	__________
Medication	Dosage	Route	Time at School

____
Administration instructions

____/____/____
Discontinue/Re-Evaluate/Follow-up Date

PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE ADMINISTRATION OF NON-PRESCRIPTION MEDICATION TO STUDENTS

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by IOWA CODE § 280.16.

______________________________ ______/______/______
Parent's Signature Date

______________________________ ______________________________
Home Telephone Number Alternate Telephone Number