SFSB OFFICE USE ONLY

ATTACHMENT J-1

HAWAII STATE DEPARTMENT OF EDUCATION
SCHOOL FOOD SERVICES BRANCH
SPECIAL DIETARY NEEDS MEDICAL FORM

This form must be:

- Thoroughly completed by the student's parent/guardian and recognized medical authority.
- Submitted to, reviewed, and approved by School Food Services Branch before meal modification is made.

Distribution:

- Original shall be kept in school file.
- School to send a copy of original J-1 to School Food Services Branch.

☐ NEW ☐ REVISED

PART I (FILLED OUT BY PARENT/GUARDIAN)			
1. Student's Last Name:	2. Student's First Name:	3. Date of Birth:	4. Grade:
Note: If student is in Pre-K s/he must be enrolled in Hawaii State Department of Education. Students enrolled in Head Start only are not eligible for special meal accommodations.			
5. School Name:		6. School Phone Number:	
7. Parent/Guardian Name:		8. Parent/Guardian Phone Number:	
9. Meals/snacks requested (check all that apply): ☐ Breakfast ☐ Lunch ☐ Afterschool Snack (Note: Afterschool Snack is available only if school is participating in USDA's sponsored program.)			
PART II (FILLED OUT BY RECOGNIZED MEDICAL AUTHORITY)			
10. Describe how the child's physical or mental impairment restricts their diet: 11. Provide an explanation of what must be done to ensure appropriate implementation: *(Note: If relevant, you may use the following sections to assist in providing this information.)*			
Dietary Need Specifications are shown below and on the next page. Please answer completely.			
12. Does the child require a nutrition or dietary supplement during school hours? ☐ YES ☐ NO			
13. If yes, what is the required supplement?			
14. Does the child receive required supplement(s) from State/Federal programs (e.g. WIC/Medicaid)? ☐ N/A ☐ YES ☐ NO			
15. Specify carbohydrates per meal (check one): ☐ N/A ☐ 45g ☐ 60g ☐ 75g ☐ Other:_____			
16. Modified Food Texture: ☐ N/A ☐ Chop (1/2") ☐ Finely Chop (1/4") ☐ Minced (1/8") ☐ Pureed ☐ Other: _____			
17. Modified Liquid Consistency: ☐ N/A ☐ Nectar-Thick ☐ Honey-Thick ☐ Pudding-Thick			

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SPECIAL DIETARY NEEDS MEDICAL FORM

18. Student's Name (Last Name, First Name):

19. Food omissions (check all that apply):	20. Recommended food alternatives (specify):
☐ Fluid milk (dairy) to drink ☐ All foods/products containing milk ingredients excluding those baked into food/product ☐ All foods/products containing milk ingredients	☐ Soy milk ☐ Water (If student is unable to consume fluid milk) ☐ Other:
☐ Eggs (e.g. scrambled eggs, eggs in raw form) ☐ All foods/products containing egg ingredients excluding those baked into food/product ☐ All foods/products containing egg ingredients	
☐ All foods/products containing wheat ingredients ☐ All foods/products containing gluten ingredients	
☐ Peanuts ☐ All Nuts ☐ Tree Nuts, specify type: _____	
☐ Soybean ☐ All foods/products containing soy ingredients ☐ All foods/products containing soy ingredients, including soy oil	
☐ Shellfish, specify type: _____ ☐ Fish, specify type: _____ ☐ All Seafood	
☐ Other:	

21. Authorization Duration: This Authorization will be followed and in effect until the date **OR** event specified below:

22. ***I have reviewed Attachment J – Accommodating Students with Special Dietary Needs in School Nutrition Programs Sections I, II, III, and attest that this diet order meets the criteria cited in this attachment.***

Signature of Recognized Medical Authority (include credentials): Date:

Print Name and Address: Phone Number:
Fax Number:

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FORM COMPLETE
SCHOOL CONTACTED ON: _____

FORM INCOMPLETE
SCHOOL CONTACTED ON: _____

FORM COMPLETE ACCOMMODATION WILL NOT BE MADE.
☐ 504 Team found the STUDENT was ineligible.

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SCHOOL FOOD SERVICES BRANCH
SPECIAL DIETARY NEEDS MEDICAL FORM

This form must be:

- Thoroughly completed by the student's parent/guardian and recognized medical authority.
- Submitted to, reviewed, and approved by School Food Services Branch before meal modification is made.

Distribution:

- Original shall be kept in school file.
- School to send a copy of original J-1 to School Food Services Branch.

☐ NEW ☐ REVISED

PART I (FILLED OUT BY PARENT/GUARDIAN)			
1. Student's Last Name: Aloha	2. Student's First Name: Napualani	3. Date of Birth: 01/01/10	4. Grade: 2nd
Note: If student is in Pre-K s/he must be enrolled in Hawaii State Department of Education. Students enrolled in Head Start only are not eligible for special meal accommodations.			
5. School Name: Ohana Elementary		6. School Phone Number: 305-0000	
7. Parent/Guardian Name: Joe Aloha		8. Parent/Guardian Phone Number: 512-111-1222	
9. Meals/snacks requested (check all that apply): ☐ Breakfast ☒ Lunch ☐ Afterschool Snack (Note: Afterschool Snack is available only if school is participating in USDA's sponsored program.)			
PART II (FILLED OUT BY RECOGNIZED MEDICAL AUTHORITY)			
10. Describe how the child's physical or mental impairment restricts their diet: Increased caloric needs 11. Provide an explanation of what must be done to ensure appropriate implementation: *(Note: If relevant, you may use the following sections to assist in providing this information.)* See below.			
Dietary Need Specifications are shown below and on the next page. Please answer completely.			
12. Does the child require a nutrition or dietary supplement during school hours? ☒ YES ☐ NO			
13. If yes, what is the required supplement? PediaSure (Vanilla)			
14. Does the child receive required supplement(s) from State/Federal programs (e.g. WIC/Medicaid)? ☐ N/A ☐ YES ☒ NO			
15. Specify carbohydrates per meal (check one): ☒ N/A ☐ 45g ☐ 60g ☐ 75g ☐ Other:_____			
16. Modified Food Texture: ☒ N/A ☐ Chop (1/2") ☐ Finely Chop (1/4") ☐ Minced (1/8") ☐ Pureed ☐ Other: _____			
17. Modified Liquid Consistency: ☒ N/A ☐ Nectar-Thick ☐ Honey-Thick ☐ Pudding-Thick			

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SCHOOL FOOD SERVICES BRANCH
SPECIAL DIETARY NEEDS MEDICAL FORM

18. Student's Name (Last Name, First Name): Aloha, Napualani

19. Food omissions (check all that apply):	20. Recommended food alternatives (specify):
☐ Fluid milk (dairy) to drink ☐ All foods/products containing milk ingredients excluding those baked into food/product ☐ All foods/products containing milk ingredients	☐ Soy milk ☐ Water (If student is unable to consume fluid milk) ☒ Other: Serve PediaSure in place of fluid milk served at school lunch.
☐ Eggs (e.g. scrambled eggs, eggs in raw form) ☐ All foods/products containing egg ingredients excluding those baked into food/product ☐ All foods/products containing egg ingredients	
☐ All foods/products containing wheat ingredients ☒ All foods/products containing gluten ingredients	
☐ Peanuts ☐ All Nuts ☐ Tree Nuts, specify type: _____	
☐ Soybean ☐ All foods/products containing soy ingredients ☐ All foods/products containing soy ingredients, including soy oil	
☐ Shellfish, specify type: _____ ☐ Fish, specify type: _____ ☐ All Seafood	
☐ Other:	

21. Authorization Duration This Authorization will be followed and in effect until the date **OR** event specified below:
Indefinitely

22. *I have reviewed Attachment J – Accommodating Students with Special Dietary Needs in School Nutrition Programs Sections I, II, III, and attest that this diet order meets the criteria cited in this attachment.*

Signature of Recognized Medical Authority (include credentials):

Jane Smith, APRN

Print Name and Address:
Jane Smith
987 Kahuna Street
Heiau, HI 99999

Date: 06/02/2018
Phone Number: 808-988-7776
Fax Number: 808-988-7777

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FORM COMPLETE
SCHOOL CONTACTED ON: _____

FORM INCOMPLETE
SCHOOL CONTACTED ON: _____

FORM COMPLETE. ACCOMMODATION WILL NOT BE MADE.
☐ 504 Team found the STUDENT was ineligible.

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