Hillsborough County Student Nutrition Services
Parent Information for Requesting Special Diets
School Year 2022-2023

Student Nutrition Overview
The Student Nutrition Services Department (SNS) strives to offer healthy, well-balanced meals. Breakfast and Lunch is offered to all children, free of charge, for the 2022-2023 school year. All meals must meet the strict nutritional standards for the National School Lunch and Breakfast program set forth by USDA. To constitute a reimbursable lunch, students must select at least three out of the five components: meat/protein, bread, fruit, vegetable, and milk. At breakfast, students must select three out of the four components. At both meals, one of the components must be either a fruit or a vegetable.

General Information Regarding Special Diets
Food substitutions/menu modifications may be requested for children with special dietary condition(s) by using Student Nutrition's ***Diet Prescription for Special Meals.*** School nutrition managers can use foods from Student Nutrition's standardized market list to meet most diet modifications that are requested. Student Nutrition does not purchase other specialized foods not included in the standardized market list, such as gluten-free pastas, or formulas. If a child needs to eliminate an item such as milk from the diet, then he/she may either choose to drink portable water free of charge, or choose to purchase another type of drink. Milk is required to be offered to all children, but it is not mandatory that a child takes milk for a complete meal. With most diets, we are able to prepare and serve flavorful menu items to your child that meets his or her special need, while still following federal guidelines for school meals.

Completing the Diet Prescription Form
It is imperative that the ***Diet Prescription for Special Meals*** is completed correctly and given to the Student Nutrition Manager at your site so we can safely serve your child. Food substitutions/menu modifications **cannot** be made without a completed form. A new form **must be** completed each school year so our records are kept up to date and the information on file is correct.

Partnering with Parents to Feed Your Child
We want to work in partnership with you to meet the needs of your child while attending school. Once the ***Diet Prescription for Special Meals*** form is completed and returned, the Student Nutrition Manager will contact the parent/guardian to discuss the special diet. In some cases, a meeting between the parent, Student Nutrition Manager, and District Dietitian may be needed to discuss available menu substitutions/modifications necessary to accommodate your child's needs. Once appropriate menu/food choices have been determined, the Student Nutrition Manager will place an 'alert' on your child's meal account and the appropriate menu will be followed.

To assist parents, SNS has created several tools located on the SNS Website (www.sdhc.k12.fl.us/sns)

- Nutrition information, including carbohydrate counts on all menu items
- Allergen information on the eight major allergens; wheat, soy, treenuts, peanuts, eggs, milk, fish, and shellfish
- 'Managing a Gluten Free Diet at School', listing our gluten free items available
- Nutrislice, (free smart phone app) and MyPaymentsPlus for obtaining a history of your child's meal choices

Hillsborough County Student Nutrition Services

DIET PRESCRIPTION FOR SPECIAL MEALS FORM

School Year 2022-2023

Student Nutrition Services is committed to serving all children nutritious meals; this includes working with children who have special dietary needs. To help us in meeting your child's dietary requirements, we require that this form be completed and returned to the Student Nutrition Manager at your child's school. Once completed, the Student Nutrition Manager will contact you to discuss menu options.

Section A- Must be completed by the Parent/Guardian

Name of Student ________________________ Student's ID ______________ Grade _____

School Name ________________________ Teacher's Name ________________________

Does the student typically receive a meal(s) from Student Nutrition Services (SNS)? ☐ **Yes** ☐ **No**

If yes, which meals provided by SNS will your child most likely eat?
☐ Breakfast ☐ Lunch ☐ Afterschool ☐ Snack ☐ Dinner

Parent/Guardian Signature Name (printed)____________________ **Signature**______________________

Daytime Phone Number______________ **Email Address**________________________ **Date**________

Section B- Must be completed by the Physician

Does the student have food allergies? ☐ **Yes** ☐ **No**
If yes, please select the allergen from the list below

Wheat
- ☐ All Wheat

Eggs
- ☐ All Egg Proteins- albumin (white) and Yolk
- ☐ Whole Egg- hard boiled and scrambled

Dairy
- ☐ All Milk Proteins- Casein, Whey, etc
- ☐ Fluid Milk
- ☐ Cheese ☐ Yogurt ☐ Ice Cream

Other: ____________________

Treenuts
- ☐ All Treenuts

Peanuts
- ☐ All Peanuts, including Peanut Oil

Soy
- ☐ All Soy Protein
- ☐ All Soy Protein except Soybean Oil

Fish
- ☐ All Fish

Shellfish
- ☐ All Shellfish

Other: ____________________

Specific Foods to Omit

____
____
____

Specific Foods to Substitute

____
____
____

I certify that the above named student needs special school food as described above,

Physician's Name (printed)________________________ **Physician's Signature** ______________________

Office Number ______________ **Date** __________

Section C- Must be completed by a Physician

Is the student Diabetic and following a controlled diet? ☐ **Yes** ☐ **No**

If yes, please describe special diet in detail. Please include the range of carbohydrates (grams) per meal that is required.

Carbohydrates (g) per meal Breakfast: __________ Lunch: __________

I certify that the above named student needs special school food as described above,

Physician's Name (printed)______________________________ **Physician's Signature** ______________________________

Office Number ________________ **Date** ______________

Section D- Must be completed by the Physician

Does the student need any special modification of dietary textures? ☐ **Yes** ☐ **No**

Indicate texture on prescribed special diet.

☐ **Soft & Bite Sized (Chopped)** (please indicate any specific instructions)

____

☐ **Minced & Moist (Ground)**(please indicate any specific instructions)

____

☐ **Pureed** (please indicate any specific instructions) ____

Indicate thickened consistency on prescribed special diet.

☐ **Mildly Thick (Nectar)** ☐ **Moderately Thick (Honey)** ☐ **Extremely Thick (Spoon)**

I certify that the above named student needs special school food as described above,

Physician's Name (printed)______________________________ **Physician's Signature** ______________________________

Office Number ________________ **Date** ______________

Section E- Must be completed by the Physician

Does the student have other special nutritional or feeding needs? ☐ **Yes** ☐ **No**

Please describe the special diet/feeding needs (attach a list of foods to be omitted and/or substituted, if needed)

____

____

____

____

____

I certify that the above named student needs special school food as described above,

Physician's Name (printed)______________________________ **Physician's Signature** ______________________________

Office Number ________________ **Date** ______________

For School Use Only

Date contacted parent ______________

Date of parent meeting ______________

Date Alert is Entered ______________

Manager's Signature ______________________________

(Form must be maintained on file in the SNS office for the current school year. Copy must be provided to the School Nurse and the District Dietitian)

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

SCHOOL HEALTH SERVICES
PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student name: ______________________________ Student #: __________ DOB: __________
Last First Middle

School: ____ Grade: __________

Known allergies: ____

As the parent/guardian of the student named above, I request the principal's designee or HOST trained personnel to administer the medication(s) described below to our/my child at school.

Medication	Amount/ Strength	Dose	Med. Exp. Date	Time	Purpose of Medication	Date Begins	Date Ends

Name of physician, APRN, or PA: ______________________________ Phone Number: __________

I understand that the provision of Florida Statute 1006.062, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). I also grant permission for school personnel to contact the physician, APRN, or PA if there are questions or concerns about the medication(s). I hereby authorize School Health Services staff to reciprocally release verbal, written, faxed or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand Hillsborough County Public Schools protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this authorization form. I understand that I am responsible to furnish/restock all supplies and medications and that any unused medication that is not retrieved by me at the end of the school year will be destroyed. I have read the attached guidelines and agree to abide by them.

Please list the medications your child takes at home (include dosage and times).

____

____

Where does the child go after school? ______________________________

Parent/guardian of students attending HOST (or any before/after-school care program), will need to make arrangements with the before/after school programs when medicines or treatments are needed.

PLEASE NOTE EARLY RELEASE DAYS MAY IMPACT ADMINISTRATION OF MEDICATION.

Early release time: ______________________ **Will medication be given? Yes No (Circle)**

______________________ ______________________ ______________________

Parent/Guardian Signature Primary Daytime Phone Date

Distribution: School Nurse and/or Trained HOST Personnel
SB 87034 (Rev. 08/22/2019)

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

SCHOOL HEALTH SERVICES
EPINEPHRINE AUTO-INJECTORS PHYSICIAN ORDERS

Student: ______________________________ Student #: ______________________________

Parent/Guardian: ______________________________ Phone: ______________________________

Physician: ______________________________ Phone: ______________ Fax: ______________

School: ______________________________ Phone: ______________ Fax: ______________

Dear Physician,

This form is being presented to you to request your orders for medical procedures. The student shown above will be attending school in the near future, and we are requiring your orders to do the procedures listed below at the school. Please complete items 1 to 9, read the statement below, and fax or return orders to the school nurse or clinic.

1. What is the child allergic to? ______________________________
2. What are the signs and symptoms of the student's allergic reaction? ______________________________

____

3. The ***Epinephrine Auto-injector*** will be kept at the school (√ one) in the clinic. ___ with the student. ___
4. Is the student aware of this allergy and its possible seriousness? Yes ___ No ___
5. Has the student been instructed in the use of the ***Epinephrine Auto-injector***? Yes ___ No ___
6. Is ***Epinephrine Auto-injector*** to be used immediately? Yes ___ No ___

   If no, at what time after bite, sting, etc. should it be given? ______________________________

   What are the specific signs that signal the need for epinephrine? ______________________________
7. Must the student carry the ***Epinephrine Auto-injector*** on their person? Yes ___ No ___
8. Will student self-administer? Yes ___ No ___
9. Please list any other specific directions to be followed. ______________________________

____

In the event of a severe allergic reaction, the ***Epinephrine Auto-injector*** is to be administered by School Health Services Nursing Staff and other trained school personnel.

Physician's Signature: ______________________________ Date: ______________________________

Physician's Printed Name: ______________________________ Phone: ______________________________

Distribution: Nurse
SB 87033 (Rev. 5/17/2018)

Hillsborough County Public Schools
Tampa, Florida

Authorization for Administration of Medication and Management of Diabetes In the School Setting

INSTRUCTIONS:

1. When the information on this form is completed and signed by the Physician and Parent, it will serve as the Physician Orders in the school setting.
2. If the Physician's Office has a comparable form it will be acceptable and can serve as the Physicians Orders.
3. The School Nurse will review the information.
4. Attach Student's Emergency Card to this form.

Date: ________________

Student's Name ________________________________ **Birth Date:** ____________

*My permission is hereby granted to **School Health Services Personnel / and or to Principal's Designee** to administer and / or allow Student to self-administer the following medications and treatments.*

I. BLOOD GLUCOSE MONITORING:

To be performed at school: Yes ____ No ____

To be performed by the Student or the Principal's Designee: Yes ____ No ____

Type of Meter: ____________ Target Range for BG: ________ mg/dl to ________ mg/dl

Time to be performed:

____ Before breakfast
____ Mid-morning: before snack
____ Before lunch
____ Dismissal
____ Before PE / Activity Time
____ After PE / Activity Time
____ Mid-afternoon
____ PRN- for signs / symptoms of high or low blood sugars

II. INSULIN ADMINISTRATION:

To be performed by Student or Health Services Personnel: Yes ____ No ____

(If YES, complete the following section)

TYPE OF INSULIN	DOSE	TIME TO BE ADMINISTERED
____ Humalog		
____ Regular		
____ NPH		
____ Lente		
____ Ultralente		
____ Other ________		

____
Insulin Delivery Method

____ # unit(s) per ____ grams

Calculate Insulin dose for Carbohydrate Intake Yes ____ No ____

SLIDING SCALE:

Blood Sugar: ________ Amount of Insulin: ________
Blood Sugar: ________ Amount of Insulin: ________
Blood Sugar: ________ Amount of Insulin: ________
Blood Sugar: ________ Amount of Insulin: ________

ADDITIONAL INSTRUCTIONS:

____
____

III. MEALS/SNACKS INSTRUCTIONS:

Can student determine correct portions & number of carbohydrate servings? Yes ____ No ____

(Parents to provide snacks if necessary and will restock supplies as needed)

Meal Event	Time/ Location	Food Content & CHO Amount
____ Breakfast		
____ Mid-morning		
____ Lunch		
____ Mid-afternoon		

Meal Event	Time/ Location	Food Content & CHO Amount
____ Before PE/Activity		
____ After PE/Activity		
____ PRN for Low BG		
____ Special Snacks Instructions:		

IV. MANAGEMENT OF HIGH BLOOD SUGAR (>200 mg/dl)

(Follow sliding scale as indicated above; if nausea / vomiting – call parent; student to be sent home)

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

_______ Increased thirst, urination, appetite
_______ Tired / drowsy / less energy
_______ Blurred vision
_______ Warm, dry, or flushed skin
_______ Other _______________

INDICATE TREATMENT CHOICES:

_______ Sugar free fluids
_______ Avoid concentrated sweets
_______ Frequent bathroom privileges
_______ May not need snack
_______ Other _______________

V. MANAGEMENT OF VERY HIGH BLOOD SUGAR (>500 mg/dl)

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

_______ Nausea / vomiting
_______ Abdominal pain
_______ Rapid, shallow breathing
_______ Weakness / muscle aches
_______ Dry mucous membranes
_______ Extreme thirst
_______ Fruity breath odor _______________
Other _______________

INDICATE TREATMENT CHOICES:

_______ Check urine for **Ketones**
_______ Notify parents if signs/symptoms present
From previous column
_______ If unable to reach parents, call 911
_______ Sugar-free fluids if tolerated
_______ Frequent bathroom privileges
_______ Stay with student and document changes in status
_______ Other _______________

VI. MANAGEMENT OF LOW BLOOD SUGAR *(range of low BS for this student)*

Less than < _______ mg/dl (may vary for individual student)

EMS will be called for Extreme Low BS

USUAL SIGNS / SYMPTOMS FOR THIS CHILD:

Change in personality
_______ Weak/ shaky/ tremors
_______ Tired/ drowsy/ fatigue
_______ Dizzy/ staggering walk
_______ Headache
_______ Inattentive/ confused
_______ Nausea/ loss of appetite
_______ Clammy/ sweating
_______ Blurred vision
_______ Irritability/ crying/ aggressive
_______ Loss of consciousness
_______ Slurred speech
_______ Seizures

INDICATE TREATMENT CHOICES:

Call EMS if unconscious or seizure
_______ 4-6 oz. Fruit juice or sweetened drink
_______ 4-6 Sugar cubes or hand candies
_______ 3 Glucose tablets
_______ Concentrated gel or tube frosting
_______ Honey, syrup, table sugar
_______ Retest BG 15-20 minutes post snack
_______ Repeat treatment until good response
_______ Follow treatment with snack of Protein/ carbohydrates
***Glucagon Injection**
_______ Other _______________
____

VII. LIST ANY OTHER MEDICATIONS TO BE GIVEN AT SCHOOL:

Medication	Dose	Time	Route	Possible side effects

I understand that treatments and procedures are being performed by the Student, School Health Staff or Principal Designee within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed and agree with the indicated instructions.

_______________ Name of School

_______________ Physician's Signature / Date

_______________ Parent's Signature / Date

_______________ School Nurse Contact

_______________ Phone Number

_______________ Phone Number

_______________ Phone Number