Medical Statement for Meal Modification

Important! Carefully read and follow the procedures for requesting a special meal accommodation. The school/site will return incomplete Medical Statements to the parent/guardian. If you have questions about this form, the district contact named in Part A below will assist you.

Schools and agencies participating in child nutrition meal programs **MUST** comply with requests for special dietary needs and adaptive equipment at no extra charge for children with a documented disability and/or medical need. If this is a life-threatening food allergy resulting in anaphylaxis, ensure the Allergy & Anaphylaxis Action Plan form is completed by school/site nursing staff.

Requests for children with a documented medical need: A completed request form must be signed by a licensed physician (MD or DO), advanced practice nurse (APN) with prescriptive authority (RXN), or physician assistant (PA). The meal modifications will continue until a licensed physician, advanced practice nurse with prescriptive authority or physician assistant requests that the modifications be changed or stopped on the Discontinuation Form, which is available from the school/site.

Parents/Guardians must communicate yearly (prior to the start of the new school year) to confirm that the meal modification on file reflects the current dietary needs of the child and the school your child is attending for that school year. Any changes throughout the school year must be communicated. It is strongly recommended that the prescribed diet order is updated annually with a new form.

Part A. Student, Parent/Guardian & School/Site Contact Information – To be completed by a parent/guardian

1. Student's Name:	2. Date of Birth:	3. School/site:
4. Parent/Guardian's Name:	5. Parent/Guardian's Phone:	
6. District Contact's Name: **Becky Wiggins, RD** **PSD Nutrition Coordinator**	7. District Contact's Phone: **970-490-3348** **rwiggins@psdschools.org**	

Part B. Prescribed Diet Order for Children with a Documented Medical Need – This must be completed by a licensed medical professional as specified above. All sections must be completed.

1. Specify the medical need and how it restricts the child's diet:

2. What major life activity is affected by this student's medical need? Example: Allergy to peanuts affects ability to breathe.

3. Type of Special Diet:
☐ Check if not applicable OR specify the type of special diet (e.g. low sodium, gluten-free, diabetic, etc.).

4. Modified Texture:	☐ Not Applicable	☐ Chopped	☐ Ground	☐ Pureed
5. Modified Thickness of Liquids:	☐ Not Applicable	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick

6. Special Feeding Equipment:
☐ Check if not applicable OR list special feeding equipment (e.g. large handled spoon, sippy cup, etc.).

7. For Egg and Milk allergies, intolerances, or sensitivities (check all that apply):

Milk, please clarify:
☐ No Fluid Milk ☐ No Cheese ☐ No Yogurt
☐ No Milk Ingredients (ie: No milk in baked goods like bread, muffins, rolls, etc.)

Eggs, please clarify:
☐ Whole eggs only (boiled, scrambled)
☐ All foods containing eggs
☐ Other

8. Foods to be Omitted and Substituted:
List specific foods to be omitted and substituted. If more space is needed, sign and attach additional sheet of paper.

Omit Foods Listed Below:	Substitute Foods Listed Below:

Licensed Physician/Advanced Practice Nurse with Prescriptive Authority/Physician Assistant Information

Signature:	Title:	
Printed Name:	Phone:	Date:

Parent/Legal Guardian Permission – To be completed by a parent or legal guardian. (See next page)

I give permission for school/site personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school/site staff. I also give permission for my child's licensed physician, advanced practice nurse with prescriptive authority or physician assistant to further clarify the prescribed diet order on this form if requested to do so by school/site personnel.

Parent/Legal Guardian's Signature & Date: