Medical Statement for Meal Modification Request

Student, Parent/Guardian, Healthcare Provider Facility Contact Information – To be completed by a parent/guardian or facility contact person.		
Student's Name:	Date of Birth:	Facility:
Parent/Guardian's Name:	Parent/Guardian's Phone Number:	
Facility Contact's Name:	Facility Contact's Phone Number:	

Prescribed Diet Order – To be completed by a licensed healthcare provider.

1. The medical condition related to the prescribed diet order and significant life activity affected.
Example: Allergy to peanuts affects the ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

3. Medical Provider's Information:

Signature: Title:

Printed Name:	Phone:	Date:

Parent/Guardian Permission – To be completed by a parent/guardian

I permit Pembroke Hill personnel responsible for implementing the prescribed diet order to discuss the special dietary accommodations with any appropriate faculty or staff and follow the prescribed diet order for meals and snacks. I also permit the medical provider to further clarify the prescribed diet order on this form if requested to do so by Pembroke Hill School personnel.

Parent/Guardian's Signature: Date: