



Colorado Springs School District 11 Food and Nutrition Services

5260 Geiger Blvd., Colorado Springs, CO 80915
Phone: 719-520-2923 Fax: 719-520-2935
<http://www.d11.org/Page/2074>

Special Dietary Needs

2018-2019 School Year

Dear Parent/Guardian:

Your child's school:

1. **Will** make meal modifications **prescribed by a licensed physician, advanced practice nurse with prescriptive authority, or physician's assistant** to accommodate a disability. Properly completed and signed paperwork is required.
2. **Will not** make school meal modifications for requests that do not rise to the level of a disability including;
 - * Food sensitivity that can be accommodated through menu choices
Note: Milk is not a required meal component and can be declined by any student.
 - * Dietary preferences for religious, ethical, or cultural reasons, or general health concerns

A disability is considered a physical or mental impairment which substantially limits one or more major life activity.

It is strongly recommended that a recognized medical authority annually update the prescribed diet order.

If this is a life-threatening food allergy resulting in anaphylaxis, ensure the *Colorado Allergy and Anaphylaxis Emergency Care and Medication Orders* form is completed by a recognized medical authority for school nursing staff.

Return the completed *Medical Statement for School Meal Modification Form*

By mail or personal delivery to:

CSSD11 Food and Nutrition Services
5260 Geiger Blvd.
Colorado Springs, CO 80915

Or by fax: 719-520-2935

If you have questions or need assistance, please contact Jamie Humphrey, Administrative Dietitian at (719) 520-2924 or Jamie.Humphrey@d11.org.

Sincerely,

Jamie Humphrey, RDN
Colorado Springs School District 11
Food and Nutrition Services Department

Medical Statement for Dietary Disability School Meal Modification form may be printed on back or attached separately.

This institution is an equal opportunity provider.

2018-2019 Medical Statement for Dietary Disability School Meal Modification
 Colorado Springs School District 11 Food and Nutrition Services Fax to: 719-520-2935

Part A. Student & School Contact Information – To be completed by a parent/guardian or school contact person

Student Name:		(Optional) School Contact Name:
Date of Birth:	Student ID #:	School Contact Phone:
School:	2018-2019 Grade:	School Contact Email:

Part B. Parent/Guardian Contact Information – To be completed by a parent/guardian or school contact person

Parent/Guardian 1 Name:		(Optional) Parent/Guardian 2 Name:
Parent/Guardian 1 Phone:		Parent/Guardian 2 Phone:
Parent/Guardian 1 Email:		Parent/Guardian 2 Email:
Home (Mailing) Address: Colorado Springs, CO Zip Code:		

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

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff. I also give permission for my child's Licensed Physician, Nurse Practitioner, or Physician Assistant to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: _____ Date: _____

Part D. Prescribed Diet Order – To be completed by the appropriate recognized medical authority.

A disability is considered a physical or mental impairment which substantially limits one or more major life activity.
 It is strongly recommended that a recognized medical authority annually update the prescribed diet order.

1. **Mechanical Modification:** Check if Not Applicable Medical Condition/Reason for Modification: _____

Modify Texture: Chopped Ground Pureed

Modify Consistency: Nectar Thick Honey Thick Spoon or Pudding Thick

Adaptive Equipment: (Specify) _____

2. **Nutrient Modification:** Check if Not Applicable Medical Condition/Reason for Modification: _____
Example: Diabetes, phenylketonuria (PKU), etc.

Nutrient to modify _____ Min Max Range _____ mg gm mL kcal per Meal Day

3. **Ingredient Modification:** Check if Not Applicable

Medical Condition: Severe Food Allergy/Anaphylaxis **Cross-contact precautions required.**

Omit: Peanut Tree Nut Soy Wheat Milk Egg Fish Crustacean Shellfish

Medical Condition: Celiac Disease **Cross-contact precautions required.**

Omit: Gluten (wheat, rye, barley, triticale, spelt, kamut, and derivatives, including barley malt)
 Allowed: naturally Gluten Free foods (rice, corn, potato, etc.) and guaranteed Gluten Free oats and products

Medical Condition/Reason for Modification: _____

Omit: _____
Indicate whole or partial ingredients to be eliminated. Example: lactose, egg yolk, or corn protein

Allowed: _____
Example: yogurt, eggs in bread/baked foods, corn starch, soy lecithin, or soybean oil not listed as an allergen

Recommended alternatives (if applicable): _____

Part E. Licensed Physician/ Advanced Practice Nurse with Prescriptive Authority / Physician Assistant Information

I certify the above named student needs special school meals as described above, due to the student's disability.		Office Stamp (preferred) or Print: Clinic: Address: City, ST, Zip: Phone: Fax:
Signature:	Date:	
Printed Name/Credentials:		