Lyon County School District
Portrait of a Learner
Learning for Life
Connected Learners
Student Ownership
Discovery Learning

Medical Request for Student Meal Modification

Meal modifications will only be provided for students with a dietary disability.
Form must be filled out completely with the required signatures to be accepted.

SECTION 1 – PARENT/LEGAL GUARDIAN TO COMPLETE THIS SECTION

Student Name (Last, First): _____ **Date of Request:** _____

Date of Birth: _____ **School Name:** _____ **Student ID #:** _____

Parent/Guardian Name: _____ **Phone #:** _____

Which meals will your child eat from the school cafeteria and how often?

☐ Both Breakfast & Lunch ☐ Breakfast ONLY ☐ Lunch ONLY

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Mon – Fri (Daily)

I authorize Lyon County School District Nutrition Services to provide the necessary diet accommodations for my child. I understand that it is my responsibility to notify Nutrition Services of any changes to my child's dietary needs, including diet-related changes, change of schools, and/or discontinuation of modified meal service.

Signature: _____ **Date:** _____

SECTION 2 – LICENSED PHYSICIAN OR RECOGNIZED MEDICAL AUTHORITY TO COMPLETE THIS SECTION

**Recognized Medical Authorities include Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN).*

Does the child have a dietary disability? ☐ Yes (describe below) ☐ No, my child and I will self-monitor.

Does the child have a food allergy or intolerance? ☐ Yes ☐ No If yes, identify foods below.

Please describe the child's physical or mental impairment and how it restricts the child's diet:

_____

Foods to omit from the child's meals (check all that apply):

☐ Fluid Milk ONLY ☐ All Dairy (including fluid milk) ☐ Soy ☐ Egg ☐ Fish

☐ Wheat/Gluten ☐ Peanuts ☐ Tree Nuts ☐ Shellfish ☐ Other: _____

If the child requires a fluid milk substitution, please specify: _____

Texture Modification (if needed):

List any foods that need the following texture modification(s). Indicate "All" if all foods need the indicated modifications.

Bite Size Pieces: _____ Finely Chopped: _____ Pureed: _____

Other (please be specific): _____

Print Name & Title: _____

Medical Signature: _____

Please return completed form to your school nurse or mail to: LCSD Nutrition Services Department, 3655 Spruce Ave., Silver Springs, NV 89429. If you have any questions, please contact the Nutrition Services Office at (775) 575-3429.