

Waterbury School District  
**MEDICAL STATEMENT FOR MEAL MODIFICATIONS**

This **double-sided form** applies to requests for meal modifications for children participating in the U.S. Department of Agriculture's (USDA) school nutrition programs. School nutrition programs include the National School Lunch Program (NSLP), School Breakfast Program (SBP), Afterschool Snack Program (ASP), Seamless Summer Option (SSO) of the NSLP, Special Milk Program (SMP), and Fresh Fruit and Vegetable Program (FFVP). Schools and institutions are required to make reasonable meal modifications for children whose physical or mental impairment restricts their diet.

**Please Note:** For submitted medical statements, the USDA requires the parent/ guardian to include:

1) information about the child's physical or mental impairment that is sufficient to allow the school food authority (SFA) to understand how the physical or mental impairment restricts the child's diet; 2) detailed steps or an explanation of what must be done to accommodate; and 3) if appropriate, the food or foods to be omitted and recommended alternatives.

**Section A - Completed by parent or guardian**

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School Attending: \_\_\_\_\_

Name of parent or guardian: \_\_\_\_\_

Phone number (with area code): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Release of Information:**

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA),

I hereby authorize \_\_\_\_\_ to release such protected health information  
(*printed name of child's medical provider*)

of my child as is necessary for the specific purpose of special diet information to **Waterbury School District**, and I consent to allow the recognized medical authority to freely exchange the information listed on this form and in my child's records with the school district as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that I may rescind permission to release this information at any time, except when the information has already been released.

**Signature of parent or guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410;
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

**\*\*The Student's Licensed Medical Provider to Complete Section B, Please See 57a on the Back of this Form\*\***

**Section B: To be Completed by the Student's Licensed Medical Provider**

*\*\*This section must be completed by the student's physician (MD), physician assistant (PA or PAC), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or registered dietitian (RD or RDN).\*\**

**Special Modifications/Restrictions:** ( ) None ( ) Yes:

If yes, please describe how the student's physical or mental impairment restricts the student's diet.

**Diet Plan:** Explain the meal modification for the student. Attach a specific diet plan if needed.

**Food Allergy** ( ) No ( ) Yes \_\_\_\_\_ Epi-Pen: ( ) Yes ( ) No

**Aspiration Risks:** ( ) No ( ) Yes; please explain: \_\_\_\_\_

**Food Omissions and Substitutions:** List foods to be omitted from the student's diet and foods to be substituted. \_\_\_\_\_

**Duration of Written Order: Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

**Food Consistency/Texture:**

- \_\_\_\_\_ Pureed (machine blended to smooth consistency, no lumps, pudding-like)  
\_\_\_\_\_ Finely Ground / Minced (pieces equal to or less than 2 mm)  
\_\_\_\_\_ Soft & Bite-Sized (cut or chopped into pieces no larger than 8mm x 8mm)  
\_\_\_\_\_ Regular (able to chew and swallow all forms of food without difficulty) – No Restrictions

**Liquid Consistency (Circle One):**

Thin (Regular)                      Mildly Thick                      Moderately Thick                      Extremely Thick

Comments: \_\_\_\_\_

**Feeding Schedule and Times:** \_\_\_\_\_

**Recommended Positioning During Feeding Times:**

- \_\_\_\_\_ Independently Upright  
\_\_\_\_\_ Supported Upright (How?): \_\_\_\_\_  
\_\_\_\_\_ Supported Reclining (How?): \_\_\_\_\_ Angle: \_\_\_\_\_  
\_\_\_\_\_ Other (Describe): \_\_\_\_\_

Please keep upright / in feeding position for at least \_\_\_\_\_ minutes after feeding/eating.

**Food Presentation:**

\_\_\_\_\_ Cup \_\_\_\_\_ Straw \_\_\_\_\_ Spoon \_\_\_\_\_ Fork \_\_\_\_\_ Bowl \_\_\_\_\_ Plate \_\_\_\_\_ Other

**Other Necessary Equipment or Relevant Information:** Indicate any other information about the student's eating or feeding patterns that will assist in providing the requested meal modification. \_\_\_\_\_

\_\_\_\_\_  
Licensed Medical Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

A Copy has been sent to:  
( ) Cafeteria Manager  
( ) School Nurse ( ) OT  
( ) PT ( ) SLP  
( ) Principal  
( ) Special Ed Supervisor/504 Coordinator  
( ) Food Services Central Office: *Modified*  
Only -- Fax # 203-346-6110