



PHYSICIAN'S REQUEST FOR MEAL MODIFICATION

Student's Name: _____ ID #: _____ Date of Birth: ____ / ____ / ____ School/Grade: _____

Parent/Guardian's Name (print): _____ Daytime Phone: _____ Email: _____

Students whose physical or mental impairment (disability) restricts their diet are eligible for meal modification in the School Breakfast and National School Lunch Program. Meal Modifications must be prescribed by a licensed physician, nurse practitioner, or physician's assistant and the required dietary regimen must be specified.

CLASSIFICATION FOR HEALTHCARE PROVIDER USE

1. **"A Person with a disability"** is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.
2. **"Physical or mental impairment"** means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.

(CITATIONS FROM SECTION 504 OF THE REHABILITATION ACT OF 1973 AND AMERICANS WITH DISABILITIES ACT OF 1990)

HEALTHCARE PROVIDER* USE ONLY

1. Explanation of the child's physical or mental impairment and how it restricts the child's diet, including allergies:

2. Specify Food Textures: Cut up/chopped in bite-size pieces: _____

Finely ground: _____

Pureed: _____

3. Special Feeding Equipment: List any special equipment or specialty utensils needed: _____

4. List foods or beverages that the student **cannot** consume: _____

5. List the foods or beverages that can be **substituted**: _____

6. Additional information: Child's food likes & dislikes: _____

Health Care Provider Office Name: _____

Address: _____ City: _____ State: _____ Office Phone: _____ Fax: _____

Health Care Provider Name: _____ Health Care Provider Signature: _____ Date: _____

Office Stamp Here:

Parent/Guardian Signature: _____ Date: _____

Return Form to School Nurse/School Office

SCHOOL USE ONLY

Copy of form to:

1. School Nurse 2. School Café Manager 3. Dept. of Nutrition Services Dietitian (email NutritionServices@collierschools.com)