

# MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

For Use in the USDA School Nutrition Programs, Child and Adult Care Food Program, & Summer Food Service Program

*This form may be used to request a meal modification for a child with a physical or mental impairment that restricts their diet. **Portions of this form must be completed by a State Licensed Healthcare Professional (who is authorized to write medical prescriptions under Illinois law) or a Registered Dietitian.***

## SECTION 1: CHILD INFORMATION

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Grade: \_\_\_\_\_

## SECTION 2: MEAL MODIFICATION INFORMATION

**TO BE COMPLETED BY A STATE LICENSED HEALTHCARE PROFESSIONAL OR REGISTERED DIETITIAN**

1. Provide a description of the child's physical or mental impairment and how it restricts their diet and/or access to meal programs.

2. Are there any food items and/or ingredients that must be avoided? ☐ Yes ☐ No

If yes, please list the food items and/or ingredients to be avoided.

List alternatives that may be provided for any items or ingredients above.

3. List any additional modifications and/or services needed to accommodate the child's impairment or disability.

## SECTION 3: SIGNATURES

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Authority Name (First & Last) \_\_\_\_\_

Medical Authority Signature \_\_\_\_\_ Date \_\_\_\_\_




SEND COMPLETED FORMS TO		
Name:	Email:	Mailing Address:
Title:	Fax:	
Facility:		
SPONSOR/SCHOOL FOOD AUTHORITY USE ONLY		
Date Received: _____		Received By: _____
Date(s) of Follow-Up Communication* _____		
<i>*Attach documentation of pertinent information received from any follow-up communication to this form.</i>		

### Nondiscrimination Statement

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 online](#) , or obtain the form 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; or
2. **Fax:**  
(833) 256-1665 or (202) 690-7442; or
3. **Email:**  
[program.intake@usda.gov](mailto:program.intake@usda.gov)

