School District 51
MESA COUNTY VALLEY
Engage, Equip, and Empower

Medical Statement for Meal Modification

Please fax the completed form to D51 Nursing Services. Fax: (970) 245-0825

Part A. Student, Parent/Guardian & School/Site Contact Information – To be completed by a parent or legal guardian.		
1. Student's Name (please print):	2. Date of Birth:	3.Grade Level:
4. School Name:	5. Homeroom:	
6. Parent/Guardian's Name (please print):	7. Parent/Guardian's Phone:	
8. Parent/Guardian Email:	9. Home Address, City, State, Zip:	

Parent/Legal Guardian Permission – To be completed by a parent or legal guardian.

I request service for my child and I give permission to the D51 Nutrition Services Staff to contact Medical Doctor or other recognized medical authority listed below on this diet order if clarification is needed.

Parent/Legal Guardian's Signature & Date:

Part B. Prescribed Diet Order- To be completed by a licensed physician (MD or DO), advanced practice nurse (APN) with prescriptive authority, physician assistant (PA), or registered dietitian (RD). *A parent/guardian may NOT complete this section*.

1.Please state the physical or mental condition/impairment(s) that affects this student's diet.

2.Please describe how the physical or mental condition/impairment(s) listed above restricts this student's diet.

3.If the impairment is a food allergy, please specify allergen(s) below:

Milk, please clarify:
- ☐ All dairy
- ☐ Specific dairy ONLY (please list dairy items student is allergic to) _____

Eggs, please clarify:
- ☐ Whole eggs only (boiled, scrambled)
- ☐ All foods containing eggs
- ☐ Other_____

- ☐ Soy
- ☐ Fish
- ☐ Shellfish
- ☐ Wheat
- ☐ Gluten

- ☐ Peanuts
- ☐ Tree-nuts
- ☐ Other_____

Can student tolerate any of these allergens in BAKED GOODS? If so please specify the allergens and foods that meet this exception:

4.Please indicate the accommodation(s) to the student's meals that is/are requested. Please recommend substitutions.

5. If the student needs texture or liquid modifications, please indicate below:

☐ Mechanical Soft Solids & Chopped Meats (Dysphagia Level 3) ☐ Fork Mashable Solids & Ground Meats (Dysphagia Level 2)
☐ Pureed Solids & Meats (Dysphagia Level 1) ☐ Other (Specify): _____
Liquid Consistency: ☐ Thin ☐ Nectar Thick ☐ Honey Thick ☐ Pudding Thick

6. Indicate additional comments about eating or feeding patterns, special equipment or utensils, and nutritional supplements.

Licensed Medical Professional Printed Name:	Licensed Medical Professional Phone Number:
Licensed Medical Professional Signature:	Date:

This institution is an equal opportunity provider.

CDE CO COLORADO Department of Education