

**Medical Statement for Dietary Disabilities School Meal Modification
Colorado Springs School District 11 Food and Nutrition Services**

Submit to: Kitchen Manager, School Nurse, Mail or deliver to **5260 Geiger Blvd. C/S, CO 80915**

Email Questions to Jamie Humphrey, RDN Jamie.Humphrey@d11.org

Part A. Student & School Contact Information – To be completed by a parent/guardian or school contact person		
Student Name:		Parent/Guardian Name:
Date of Birth:	Grade:	Parent/Guardian Phone:
School Site:		Parent/Guardian Email
Mailing address:		
Part B. Prescribed Diet Order – To be completed by the appropriate recognized medical authority. See Part C for qualified professionals. A disability is considered a physical or mental impairment which substantially limits one or more major life activity. It is strongly recommended that a recognized medical authority annually update the prescribed diet order.		
1. Specify the medical need and how it restricts the child's diet:		
2. What major life activity is affected by this student's medical need? Example: Allergy to peanuts affects ability to breathe.		
3. Modify Liquids: ☐ No Liquids ☐ IDDSI 3: Moderately Thick ☐ IDDSI 2: Mildly Thick ☐ IDDSI 1: Slightly Thick Modify Texture: ☐ IDDSI 7: Easy Chew ☐ IDDSI 6: Soft/Bite Sized ☐ IDDSI 5: Minced Moist ☐ IDDSI 4: Pureed ☐ IDDSI 3: Thin Pureed Special Feeding Equipment: (Specify) _____		
4. Ingredient Modification: ☐ Check if Not Applicable ☐ Medical Condition: <u>Severe Food Allergy/Anaphylaxis</u> Cross-contact precautions required. Omit: ☐ Peanut ☐ Tree Nut ☐ Soy ☐ Wheat ☐ Milk ☐ Egg ☐ Fish ☐ Crustacean Shellfish ☐ Sesame ☐ _____ Can student have foods made in a facility that may use allergens listed above? ☐ YES ☐ NO Can student have foods that are made on shared equipment? ☐ Yes ☐ NO Can student have foods labeled as "May Contain" allergens listed above? ☐ YES ☐ NO If student has a milk or egg allergy, can they tolerate these baked into products? ☐ YES ☐ NO ☐ Medical Condition: <u>Celiac Disease</u> Cross-contact precautions required. ☐ Medical Condition: <u>Lactose Intolerance</u> Omit: ☐ Yogurt ☐ Cheese ☐ Milk baked into foods (example: goldfish crackers, muffins, pancakes, etc.) ☐ Butter ☐ Ranch dressing made with buttermilk ☐ _____ Specify Allowable Substitutions: _____		
Part C. Licensed Physician/ Advanced Practice Nurse with Prescriptive Authority / Physician Assistant / Registered Dietitian Information		
I certify the above named student needs special school meals as described above, due to the student's disability.		Office Stamp (preferred) or Print: Clinic: Address: City, ST, Zip: Phone: Fax:
Signature:	Date:	
Printed Name/Credentials:		
Part D. Parent/Guardian Permission – To be completed by a parent/guardian		
I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff. I also give permission for my child's Licensed Physician, Nurse Practitioner, Physician Assistant, or Registered Dietitian to further clarify the prescribed diet order on this form if requested to do so by school personnel.		
Parent/Guardian's Signature:		Date: