Medical Statement for Fluid Milk Modification Only

Schools and agencies participating in child nutrition meal programs **MUST** comply with requests for special dietary needs and adaptive equipment at no extra charge for children with a documented disability and/or medical need. If this is a life-threatening food allergy resulting in anaphylaxis, ensure the Allergy & Anaphylaxis Action Plan form is completed by school/site nursing staff.

Requests for children with a documented medical need for fluid milk allergy or intolerance only. If your child needs to restrict all dairy items use a regular Meal Modification Form. The meal modifications will continue until a request that modifications be changed or stopped on the Discontinuation Form, which is available from the school/site. It is strongly recommended that the prescribed diet order is updated annually with a new form.

Part A. Student, Parent/Guardian & School/Site Contact Information – To be completed by a parent/guardian or school		
Student's Name:	Date of Birth:	School/site:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
School Contact's Name:	School Contact's Phone:	

Part B. Prescribed Diet Order for Children with a Documented Medical Need –All sections must be completed.	
1. Specify the medical need and how it restricts the child's diet:	
2. What major life activity (digestion, breathing, etc) is affected by this student's medical need?	
3. Food to be Omitted and Substituted:	
Omit Foods Listed Below:	Substitute (Select One):
ALL FLUID COW'S MILK	☐ **WATER** ☐ **JUICE** ☐ **PLANT-BASED MILK**

Parent OR Licensed Physician/Advanced Practice Nurse with Prescriptive Authority/Physician Assistant/Registered Dietitian Information		
Signature:	Title:	
Printed Name	Phone:	Date:

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

I give permission for school/site personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodation with any appropriate school/site staff. I also give permission to my child's licensed physician, advanced practice nurse with prescriptive authority, registered dietitian, or physician assistant to further clarify the prescribed diet order on this form if requested to do so by school/site personnel.

Parent/Legal Guardian's Signature & Date:

This institution is an equal opportunity provider.