

Medical Statement to Request School Meal Modification

Important! Complete this form when requesting a meal accommodation for a student because of a disability, food allergy, intolerance, or other medical condition. School Nutrition will use the information provided to determine and implement the appropriate school meal accommodation in accordance with applicable federal and state requirements.

1. Meal Accommodation related to a disability or medical condition:

- A school is required to provide reasonable meal accommodations when a student's disability restricts the student's diet, and the accommodation is supported by an appropriate written medical statement completed by a state-licensed healthcare professional or registered dietitian, or by an applicable meal accommodation requirement in the student's IEP or Section 504 plan.
- Parts A, B, and C must be completed as applicable before School Nutrition can fully implement the prescribed accommodation. If information is incomplete or unclear, School Nutrition will contact the parent/guardian and, when authorized, the medical authority for clarification.
- A new medical statement from the medical authority is not required each school year. The accommodation will remain in effect until School Nutrition receives written documentation of a change or written notice that the accommodation is no longer needed.

2. Exclusion of fluid cow's milk for a non-disability dietary need:

- A parent/guardian may request that fluid cow's milk not be served to a student for a non-disability dietary need, including a vegan diet or religious, ethical, or cultural practice.
- Parts A and D of this form must be completed for School Nutrition to implement the request.
- These exclusions will continue until a parent/guardian provides written communication changing or discontinuing the request.

Part A. Student, Parent/Guardian & School Contact Information – To be completed by a parent/guardian or school contact person

Student's Name:	Date of Birth:	School:
Parent/Guardian's Name:	Parent/Guardian's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a state-licensed healthcare professional or registered dietitian as specified above.

1. Specify the disability, food allergy/intolerance, or medical condition related to the prescribed diet order.

2. What is affected by the above condition? Example: Allergy to peanuts affects the ability to breathe.

3. Modified Texture:	☐ Chopped	☐ Ground	☐ Pureed
4. Modified Thickness of Liquids:	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick

5. Special Feeding Equipment:
List special feeding equipment (e.g., large-handled spoon, sippy cup, etc.).

6. Type of Food Allergy (check all that apply):

☐ wheat ☐ fish ☐ shellfish ☐ soy ☐ peanuts ☐ tree nuts ☐ eggs ☐ milk

Others _____



7. Foods to be Omitted and Substituted: List specific foods to be omitted and substituted. If more space is needed, sign and attach an additional sheet of paper.

Omit Foods Listed Below:	Substitute Foods Listed Below if Available:

8. Medical Authority/Registered Dietitian Information

Signature:	Title:	
Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I request that ECISD School Nutrition implement the meal accommodation described on this form for my child. I authorize ECISD School Nutrition and other ECISD personnel who need this information to safely implement my child's approved meal accommodation to use and discuss the health or medical information provided on this form for that purpose. I also authorize the School Nutrition Dietitian or other designated ECISD personnel to contact the medical authority or registered dietitian identified on this form when clarification of the prescribed meal accommodation is necessary.

Parent/Guardian's Signature: _____ Date: _____

Part D. Request Exclusion of Fluid Cow's Milk for a Non-Disability Dietary Need – To be completed by a parent/guardian

☐ YES, please do not serve fluid cow's milk to my child as part of school meals.

Parent/Guardian's Signature: _____ Date: _____

(School Nutrition Department to complete)
ECISD School Nutrition Notes: _____

ECISD RD Signature: _____ Date: _____

This institution is an equal opportunity provider.

