Medical Statement for Meal Modification

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: A completed request form must be signed by a licensed physician (MD or DO), advanced practice nurse (APN) with prescriptive authority (RXN), physician assistant (PA), or registered dietitian (RD).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/site contact person.		
1. Student's Name:	2. Date of Birth:	3. School/site:
4. Parent/Guardian's Name:	5. Parent/Guardian's Phone:	
6. School/site Contact's Name:	7. School/site Contact's Phone:	

Part B. Prescribed Diet Order for Children with a Documented Medical Need – This must be completed by a licensed medical professional as specified above. All sections must be completed.					
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. Type of Special Diet:					
4. Modified Texture: ☐ No restrictions	☐ IDDSI 7: Easy Chew	☐ IDDSI 6: Soft /Bite Sized	☐ IDDSI 5: Minced Moist	☐ IDDSI 4: Pureed	☐ IDDSI 3: Thin Pureed
5. Modified Liquids: ☐ No restrictions	☐ No Liquids	☐ IDDSI 3: Moderately Thick		☐ IDDSI 2: Mildly Thick	☐ IDDSI 1: Slightly Thick
6. Liquid Intake Restriction: ☐ Check if not applicable					
7. Special Feeding Equipment: ☐ Check if not applicable					
8. Foods to be Omitted and Substituted: List specific foods to be omitted and substituted. If more space is needed, sign and attach additional sheet of paper.					
Omit Foods Listed Below:			Substitute Foods Listed Below:		

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 accommodations with any appropriate school/site staff. I also give permission for 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.