Medical Statement for Meal Modification

USDA regulation 7 CFR Part 15b requires substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability with substitution requests which fall outside of the meal pattern must be supported by a statement signed by a licensed healthcare professional. According to USDA Memo SP 26-2017, the statement must include all of the following:

- The child's disability and explanation of how the disability restricts the child's diet
- Major life activity affected by the disability
- The food or foods to be omitted from the child's diet **and** the food or choice of foods that must be substituted

Important! Carefully read and follow the procedures for requesting a special meal accommodation. The Child Nutrition office will return incomplete Medical Statements to the parent/guardian. If you have questions about this form, please contact the Director of Child Nutrition, Miranda Martin at Miranda.martin@phxschools.org or 602-257-3742.

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), or physician assistant (PA).

Please plan to send meals with your child until you receive verification that your child's special diet request has been reviewed and the appropriate Child Nutrition team members have been trained on safe procedures for serving your student.

The meal modifications will continue until a licensed physician, advanced practice nurse with prescriptive authority or physician assistant requests that the modifications be changed or stopped on the Discontinuation Form. It is strongly recommended that the prescribed diet order is updated annually with a new form.

If this is a life-threatening food allergy resulting in anaphylaxis, students must have an Emergency Action Plan in place at school.

Part A. Student, Parent/Guardian & School/Site Contact Information – To be completed by a parent/guardian. **ALL SECTIONS MUST BE COMPLETED.**		
1. Student's Full Name:	2. Student's Date of Birth:	Grade Level:
3. School:		
4. Parent/Guardian's Name:	5. Parent/Guardian's Phone #:	
6. Parent/Guardian's Email Address:	7. Other parent/guardian contact name & information (optional):	

Mark the Child Nutrition programs this student will participate in:

☐ National School Breakfast Program ☐ National School Lunch Program ☐ Afterschool Supper/Snack

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:

☐ Check if not applicable OR specify the type of special diet (e.g. low sodium, gluten-free, etc.)

4. Modified Texture:	☐ Not Applicable	☐ Chopped	☐ Ground	☐ Pureed
5. Modified Thickness of Liquids:	☐ Not Applicable	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick

6. Special Feeding Equipment: _____

☐ Check if not applicable OR list special feeding equipment (e.g. large handled spoon, sippy cup, etc.).

7. 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: (Please do not write "N/A")
	Egg allergy: ☐ Omit egg in all forms **OR** ☐ Baked/Cooked eggs OK	Dairy: ☐ No fluid milk ☐ No cheese ☐ No yogurt ☐ No milk as an ingredient (rolls, bagels, etc.)	

Licensed Physician/Advanced Practice Nurse with Prescriptive Authority/Physician Assistant Information (REQUIRED):

Signature:	Title:	
Printed Name	Phone:	Date (include year):

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

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 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 (include year):**

Turn in completed form to Miranda Martin, Child Nutrition Director, at Support Services (120 E. Grant St. Phoenix, AZ 85004) or Miranda.martin@phxschools.org

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CHILD NUTRITION
Phoenix Elementary School District #1