Center for Disability Services

Kevin G Langan School
Prospect School
CloverPatch Preschool

Request for Meal Modification
This form is for a request for a meal modification for special diets including food allergies. A physician completing this form confirms your student has a medical necessity for a modified diet (NOT food preferences).

Student Name: _____	**Date of Birth: _____**
Parent/Guardian: _____	**Phone: _____**
Mailing Address: _____	**City/State/Zip: _____**
School: _____	**Grade/Classroom: _____**

Medical Release Statement: I, _____ the parent/guardian of the above listed student consent to the release of pertinent dietary information between medical provider and school as needed to meet the dietary needs of student. All information will be kept confidential.

Provider name: _____ Provider phone: _____

Signature of Parent/Guardian: _____ Date: _____

Meal Modification Medical Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Federal law and USDA regulation require nutrition programs to make reasonable meal modifications to accommodate children with disabilities. Under the law, a disability is an impairment that substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences.

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1. **List food allergy:**

2. **Describe the impairment and how it restricts the student's diet** (i.e., how the ingestion/contact with the food impacts the student):

3. **Explain what must be done to accommodate the student's diet** (i.e., specific food(s) to be omitted/avoided from the student's diet):

4. **List food(s) and/or beverages to be omitted or modified:**

5. **List recommended alternatives for omitted foods/beverages:**

Diet Prescription: For carbohydrate or protein restriction, include level (grams) for each meal. (If restriction is due to diabetic diagnosis Diabetic Care Plan required):

Food Texture Modification:

IDDS level: _____ Liquids Modification Level: _____

OPWDD modification level: _____ Pleasure Dinning: _____

Provider Signature: _____Date: _____Provider Stamp:

NPI number: _____ License number: _____

Provider Office Phone: _____

Date completed delivered to school nurse: _____

Date to cafeteria: _____ Date to main office: _____