Medical Statement:
Request for Special Meals and Milk Substitutions

To Be Completed by Parent/Guardian. *Please Print.*	
School District:	School Site: Grade: Teacher:
Student Name: Preferred Name (if applicable):	☐ Male ☐ Other ☐ Female ☐ Choose not to disclose
Name of Parent/Guardian:	Phone Number: Email:

Signature of Parent / Guardian:_____

The following sections must be completed by a **licensed medical physician**. *Please Print.*

Requesting Accommodation For:

- ☐ **Life** threatening (anaphylactic) food allergy
- ☐ **Non-life** threatening food allergy
- ☐ Celiac Disease
- ☐ Lactose Intolerance and is requesting a milk substitution **(not for dairy allergy)**
- ☐ Chewing/swallowing disorder and is requesting texture modification
- ☐ Student has diabetes and has a diet order for carbohydrate allowance
  Breakfast_____ (g) Lunch_____ (g) (**Please attach a copy of the diet order)**
- ☐ Student has a special dietary need not listed above **(please explain below)**

State disability or medical condition requiring special meal, accommodation or fluid milk substitution (i.e. life-threatening food allergy to peanuts):

_____

Please provide a description of major life activities affected:

_____

Diet prescription or accommodation: (Please describe in detail for appropriate implementation. Attach another sheet if needed):

_____

The following section must be completed by a **licensed medical physician**. *Please Print.*	
Foods to be Omitted:	Foods to Substitute:

Texture Modification
To receive texture modification, a signed diet prescription must be attached. Please indicate modification type and list all foods that require modifications.

Signature of Physician and Credentials (required):	**Printed Name:**
Phone Number:	**Date:**
Parent/Guardian Signature (required):	**Printed Name:**
Phone Number:	**Date:**

For Food and Nutrition Services Use Only:

□ Approves Request □ More Information Needed □ Denies Request

Notes: