



Medical Statement: Request for Special Meals and Milk Substitutions

To Be Completed by Parent/Guardian. <i>Please Print.</i>	
School District:	School Site: Grade: Teacher:
Student Name:	<input type="checkbox"/> M <input type="checkbox"/> F
Name of Parent/Guardian:	Phone Number: Email:

Signature of Parent / Guardian: _____

The following sections must be completed by a licensed medical physician. Please Print.
<p>Check Box that applies:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Student has a life threatening (anaphylactic) food allergy and is requesting a special meal or accommodation. <input type="checkbox"/> Student has a non-life threatening food allergy and is requesting a special meal or accommodation. <input type="checkbox"/> Student has Celiac Disease and is requesting a special meal or accommodation. <input type="checkbox"/> Student is lactose intolerant and is requesting a milk substitution. <input type="checkbox"/> Student has a chewing/swallowing disorder and is requesting texture modification.
<p>State disability or medical condition requiring special meal, accommodation or fluid milk substitution (i.e. life-threatening food allergy to peanuts):</p> <hr/>
<p>Please provide a description of major life activities affected:</p> <hr/>
<p>Diet prescription or accommodation: (Please describe in detail for appropriate implementation. Attach another sheet if needed):</p> <hr/>

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: