



Medical Statement for Meal Modification

Updated July 1, 2022

PLEASE NOTE: No special meal accommodations will be made for students unless they have a documented medical need. If your student's special dietary need does not fall under a documented medical need, please contact Nutrition Services for the ingredient information available for all menu items at 518-993-4000 to make meal selections from the regular school menu to meet your child's needs. While this ingredient list is accurate to the best of our knowledge, this document is for informational purposes only and is based on information that the manufacturers provide to the District. All items and allergens are subject to change without notice and the District makes no representations or warranties whatsoever as to the accuracy or completeness of the information contained herein.

Important! Carefully read and follow the procedures for a dietary disability. Any incomplete Medical Statement will be returned to the parent/guardian. If you have questions about this form, please contact Lauri Broady, Director of School Nutrition at lauri.broady@fortplain.org

Fort Plain Central School Nutrition Services WILL:

- Make meal modifications (substitutions) prescribed by a recognized medical authority (RMA) to accommodate a dietary disability based on a medical statement completed and signed by a licensed RMA.
- Make modifications (substitutions) for students as called for in their Section 504 or an IEP plans with a medical statement completed and signed by a licensed RMA.

Fort Plain Central School Nutrition Services WILL NOT:

- Make meal modifications (substitutions) without a completed and signed Medical Statement documenting a medical need.
- Make substitutions for fluid cow's milk or other meal components for other reasons outside of a documented medical need.

Completed meal modification request should be submitted to your student's school RN or Nutrition Services at 25 High St, Fort Plain, NY 13339 or lauri.broady@fortplain.org. A meeting will be set up as needed.

This institution is an equal opportunity provider.

Medical Statement for Meal Modification

Important! Carefully read and follow the procedures for requesting a special meal accommodation. The school/site will return incomplete Medical Statements to the parent/guardian. If you have questions about this form, the school/site contact named in Part A below will assist you. 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), or physician assistant (PA). 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, 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: Lauri Broady		7. School/site Contact's Phone: 518-993-4000		
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: <input type="checkbox"/> Check if not applicable OR specify the type of special diet (e.g. low sodium, gluten-free, diabetic, etc.)				
4. Modified Texture:	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Chopped	<input type="checkbox"/> Ground	<input type="checkbox"/> Pureed
5. Modified Thickness of Liquids:	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Nectar	<input type="checkbox"/> Honey	<input type="checkbox"/> Spoon or Pudding Thick
6. Special Feeding Equipment: _____ <input type="checkbox"/> 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:	
Licensed Physician/Advanced Practice Nurse with Prescriptive Authority/Physician Assistant 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 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:				

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