

## Medical Statement for Meal Modifications Students with a Disability

This form is required by the U.S. Department of Agriculture (USDA) for students with a disability that requires a meal modification under the National School Lunch Program (NSLP), School Breakfast Program (SBP), or other State/Federally funded child nutrition programs administered through DESE.

### PART A: STUDENT INFORMATION

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

Grade/Classroom: \_\_\_\_\_

### PART B: DISABILITY INFORMATION (To be completed by a Licensed Medical Professional)

1. Does the student have a disability that restricts their diet? ☐ Yes ☐ No

If yes, describe the student's disability or medical condition:

\_\_\_\_\_

2. How does the disability restrict the student's diet?

\_\_\_\_\_

\_\_\_\_\_

3. What major life activity is affected? (e.g., eating, breathing, digestion)

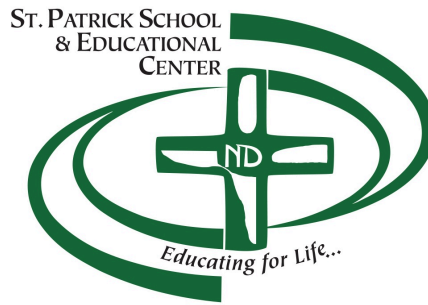
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### PART C: MEAL MODIFICATION REQUIRED

4. Foods to be OMITTED:

\_\_\_\_\_

\_\_\_\_\_



5. Foods to be SUBSTITUTED:

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6. Is texture modification required? ☐ Yes ☐ No

If yes, describe:

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#### PART D: MEDICAL PROFESSIONAL AUTHORIZATION

Name of Licensed Medical Professional (print): \_\_\_\_\_

Professional Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### PART E: PARENT/GUARDIAN ACKNOWLEDGMENT (Optional)

Parent/Guardian Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating against any person on the basis of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity.

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