BYRON BERGEN CENTRAL SCHOOL
Medical Statement for Meal Modifications Form

This form applies to requests for meal modifications for children participating in the U.S. Department of Agriculture's (USDA) school nutrition programs. School nutrition programs include the National School Lunch Program (NSLP) and the School Breakfast Program (SBP). Schools and institutions are required to make reasonable meal modifications for children whose physical or mental impairment restricts their diet.

Note: The USDA requires that the medical statement includes: 1) information about the child's physical or mental impairment that is sufficient to allow the school food authority (SFA) to understand how the physical or mental impairment restricts the child's diet; 2) an explanation of what must be done to accommodate the child's disability; and 3) if appropriate, the food or foods to be omitted and recommended alternatives. **Schools and institutions should not deny or delay a requested meal modification because the medical statement does not provide sufficient information.** When necessary, schools and institutions should work with the child's parent or guardian to obtain the required information.

Section A – Completed by parent or guardian

1. Name of child: _____ 2. Birth date: _____
3. Name of parent or guardian: _____

4. Phone number: _____ 5. E-mail address: _____

6. Address: _____City: _____State: _____Zip: _____

7. In accordance with provisions of the Health Insurance Portability and Accountability Act (HIPPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize

_____

name of child's recognized medial authority

to release such protected health information of my child as is necessary for the specific purpose of special diet information to Caledonia-Mumford Central School and I consent to allow the recognized medical authority to freely exchange the information listed on this form and in my child's records with the district as necessary. I understand that I may refuse to sign this authorizations without impact on the eligibility of my request for a special diet for my child. I understand that I may rescind permission to release this information at any time, expect when the information has already been released.

8. Signature of parent or guardian: _____ Date: _____

Section B – Completed by child's recognized medical authority

This section must be completed by the child's physician, physician assistant, doctor of osteopathy, or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

10. **Physical or mental impairment:** Does the child have a physical or mental impairment that restricts the child's diet?
☐ **No** ☐ **Yes:** Describe how the child's physical or mental impairment restricts the child's diet.

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11. **Diet plan:** Explain the meal modification for the child. Attach a specific diet plan, if needed.

12. **Food omissions and substitutions:** List foods to be omitted from the child's diet and foods to be substituted**.**

13. **Food texture:** List foods that require a change in texture. Indicate "all" if all foods should be prepared in this manner.

- ☐ Cut up or chopped into bite-size pieces: _____
- ☐ Finely ground: _____
- ☐ Pureed:___

14. **Equipment:** List any special equipment or utensils needed.

15. **Additional information:** Indicate any other information about the child's eating or feeding patterns that will assist in providing the requested meal modification.

Section B – Completed by child's recognized medical authority, continued

16. Name of recognized authority: _____

17. Phone number: _____

_____

18. Signature of recognized medical authority: _____

19. Date: _____