PROUD TRADITIONS, EXCITING FUTURES
DICKINSON
INDEPENDENT SCHOOL DISTRICT

Medical Statement Form for Meal Accommodations

School Year:_____________

Student's Name (Last, First) ____Date of Birth _____________________

School ____Grade_______________ID__________

Parent/Guardian ____Phone ___________________________

School Nurse ____Phone ___________________________

I give Health Services/ Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

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Parent/Guardian Signature Date

Does the student have a medical disability which affects one of the major life functions which necessitates a meal accommodation?

YES ☐ NO ☐

If Yes, complete the following sections. To be completed by a licensed healthcare professional:

Section A. How does this medical disability impact the student's diet?

Section B. What meal accommodation(s) are appropriate to address the student's medical disability?

Please complete each box for applicable meal accommodation and provide a detailed explanation for each accommodation.

1. Food Items or ingredients not to be served

For Example: □ No Fluid Dairy Milk □ No Milk Products (yogurt, cheese, etc) □ No Milk Protein/Milk Ingredients (in baked goods, etc.) □ No Whole Eggs □ No Eggs as an ingredient□ No Wheat/Gluten □ No Peanuts □ No Tree Nuts□ No foods processed in a facility that contains nuts□ No Seafood □ No Soy□ Other

2. Suggested substitutions for food items not served

3. Specific information on portion sizes for food items

4. Specific description of texture modifications for specific food item

5. Special utensils

6. Other

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability , as indicated.

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Signature of Licensed Healthcare Professional Date Office Phone Office Fax

Please return completed form to school nurse. Any change in accommodations must be requested in writing by licensed healthcare provider.

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