MEDICAL STATEMENT TO REQUEST MEALS MODIFICATIONS

Child's Name:	Date of Birth:
Name of Parent/Guardian:	Parent/Guardian Phone Number:

This form is intended to document any disability or medically diagnosed condition that requires a meal modification or substitution for a child in our care. Food preferences alone do not qualify for meal accommodations and are not an appropriate use of this form.

MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER:

Disability or medical condition that requires a special meal or accommodation: (i.e. juvenile diabetes, peanut allergy, etc.)

Diet prescription and/or accommodation:
(Describe in detail to ensure proper implementation, for example "All foods must be either in liquid or pureed form. Child cannot consumer any solid foods.")

Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Adaptive equipment:
Describe specific equipment required to assist the child with dining.

Foods to be omitted and substitutions.
List specific foods to be omitted and required substitutions. Any fluid milk substitute must meet the nutrient standards for non-dairy beverages offered as milk substitutes. Oat milk will be provided by the center as a substitute for cow's milk.

FOODS TO BE OMITTED	SUBSTITUTED FOODS

Medical Authority Printed Name:	Title:	Telephone Number:
SIGNATURE OF MEDICAL AUTHORITY:		Date: