***Medical Statement for Diet Modification***

*(Insert Name of School Nutrition Program)*

Submit completed form to: *(Insert Name of School Nutrition Program Contact Information)*. Incomplete forms will be returned to the parent/guardian. **Any changes require the submission of a new form.**

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| **Section I. Student, Parent/Guardian Contact Information** | | | | |
| Student Name: | | DOB: | School: | |
| Parent/Guardian Name: | | Parent/Guardian Phone: | | |
| ***The following must be completed by the child’s licensed medical provider (M.D. or D.O., PA, NP). Incomplete responses may delay the ability to provide the requested accommodation. All questions must be answered.*** | | | | |
| **Section II. Diet Prescription** | | | | |
| **1. Explain how the child’s medical condition affects their diet:** | | | | |
| **2. Specify the type of special diet being requested (e.g. Diabetic, Gluten-Free):**  N/A | | | | |
| **3. Does the student need texture modification?** Yes No  If yes, please specify: Chopped Ground Pureed Thickened Liquids Other | | | | |
| **4. Does the student have a Food Intolerance?** Yes No  If yes, please check:  Cow’s Milk  Other (specify): | | | | |
| **5. Does the student have a Food Allergy?** Yes No  If yes, please check: Milk Protein Wheat Soy Peanuts Fish Eggs Tree Nuts Shellfish  Other (specify):  Is the student at risk of anaphylaxis due to the above mentioned food allergy? Yes No | | | | |
| **6. List the Foods/ingredients to be Omitted:** | **7. List the Foods to be Substituted:** | | | |
| **I certify that the above named student needs modified schools meals as described above because of a disabling medical condition which affects their diet.** | | | | |
| Signature of Licensed Medical Provider: | | | | Date: |
| Printed Name: | Phone: | | | |
| **Parent/Legal Guardian Permission**  I give permission for the above named school/district to follow the specified dietary instructions on this form and agree to allow the school/district to share this information with school nutrition program staff and the school nurse. I agree to allow the provider listed on this form and school/district personnel to discuss the information listed on this form. | | | | |
| **Parent/Legal Guardian Signature & Date:** | | | | |

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To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at [How to File a Program Discrimination Complaint](https://www.ascr.usda.gov/how-file-program-discrimination-complaint) and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

The Maine Human Rights Act prohibits discrimination because of race, color, sex, sexual orientation, age, physical or mental disability, genetic information, religion, ancestry or national origin.

If you wish to file a discrimination complaint electronically, please select[**File a Complaint**](https://www.maine.gov/mhrc/file/instructions)and complete an intake questionnaire. Before completing this process, it may be helpful to review relevant links under Guidance. If you are not sure how the Maine Human Rights Act may apply to, you please review the publication "[What It Is! How It Works!](https://www.maine.gov/mhrc/about/what)". Maine is an equal opportunity provider and employer.