

## Medical Statement for Meal Modifications in School Nutrition Programs

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), School Breakfast Program (SBP), Afterschool Snack Program (ASP), Seamless Summer Option (SSO) of the NSLP, Special Milk Program (SMP), and Fresh Fruit and Vegetable Program (FFVP). Schools and institutions are required to make reasonable meal modifications for children whose physical or mental impairment restricts their diet. See *Instructions* page for additional guidance.

**Please Note:** For submitted medical statements, the USDA requires the parent/guardian 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) detailed steps or 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.

### Section A – Completed by parent or guardian

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

5. E-mail address:

4. Phone number (with area code):

6. Address: City: <sup>State:</sup> Zip: 7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family

Educational Rights and Privacy Act (FERPA), I hereby authorize

*printed name of child's recognized medical authority*

to release such protected health information of my child as is necessary for the specific purpose of special diet information to

and I consent to allow the recognized medical authority to freely

*printed name of school district*

exchange the information listed on this form and in my child's records with the school district as necessary. I understand that I

may refuse to sign this authorization 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, except when the information has already been released.

9. Date:

8. Signature of parent or guardian:

### 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 in detail how the child's physical or mental impairment restricts the child's diet.

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

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

## Medical Statement for Meal Modifications in School Nutrition Programs

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

13. **Texture modification:** Texture and liquid modifications should align with IDDSI (<https://iddsi.org/Framework>) recommendations.

**Food:** Regular(7) Easy to Chew(7) Soft & Bite-sized(6) Minced & Moist(5) Pureed(4) Liquidized(3) **Liquids:** Thin(0) Slightly Thick(1) Mildly Thick(2) Moderately Thick(3) Extremely Thick(4)

14. **Special Feeding Equipment:** List any special equipment or specialty 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.

16. Printed name of recognized medical authority: 17. Phone number (with area code):

18. Signature of recognized medical authority: 19. Date: 20. Office stamp:

As policies indicate, provide information/copy to:

Cafeteria/FSMC Date: 504 Committee Date: School nurse/Clinic Date: Filed with student records Date:

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 on the basis of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that

The Florida Department of Agriculture and Consumer Services is committed to a policy of equal opportunity/ action for all qualified persons. The Florida Department affirmative of Agriculture and Consumer Services does not discriminate in employment practice, education program, or educational

any

administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/>

default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in

sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must

activity on the basis of age, ancestry, color, criminal record (in state employment and licensing), genetic information, intellectual disability, learning disability, marital status, be submitted to USDA by:

mental disability (past or present), national origin, physical disability (including blindness), race, religious creed, retaliation for previously opposed discrimination or coercion, sex (pregnancy or sexual harassment), sexual orientation, veteran status or workplace hazards to reproductive systems, unless there is a bona fide occupational qualification excluding persons in any of the aforementioned protected classes.

- (1) mail: U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
- (2) fax: (833) 256-1665 or (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

Inquiries regarding the Florida Department of Agriculture and Consumer Service's non-discrimination policies should be directed to: The Division of Food, Nutrition and Wellness, 850-617-7400

Florida Department of Agriculture and Consumer Services • Revised September 2025 • Page 2 of 4

## INSTRUCTIONS

**“A Person with a disability”** is defined as any person who has a physical or mental impairment that substantially limits one or

more major life activities, has a record of such impairment, or is regarded as having such an impairment.

**“Physical or mental impairment”** means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss

affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including

speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental

or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.

**“Major life activities”** include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating,

sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory,

circulatory, endocrine, and reproductive functions..

**“Has a record of such an impairment”** is defined as having a history of or has been classified (or misclassified) as having a

mental or physical impairment that substantially limits one or more major life activities.

(CITATIONS FROM SECTION 504 OF THE REHABILITATION ACT OF 1973 AND  
AMERICANS WITH DISABILITIES ACT OF 1990)

MEDICAL STATEMENT TO REQUEST  
SPECIAL MEALS AND/OR ACCOMMODATIONS  
INSTRUCTIONS

1. **Child Name:** Print the name of the student that is with requesting a meal modification.
2. **Date of Birth:** Print the date of birth of the student in 'month/day/year' format.
3. **Parent or Guardian Name:** Print the name of the person requesting the student's medical statement.
4. **Telephone Number:** Print the primary telephone number of the parent or guardian.
5. **E-mail Address:** List an email address that is current and checked regularly. 6. **Address:** Provide a home address where the student resides most of the time. 7. **Name of Child's Recognized Medical**

**Authority:** Name of healthcare provider signing this form

**Name of School District:**

**8. Parent or Guardian Signature:** Signature of the person requesting the student's medical statement.

**9. Date:** Print the date the parent or guardian signed the document.

**10. Check One:** Check (✓) a box to indicate whether the student has a disability or does not have a disability.

If the Student has a disability, provide a description of the student's Major Life Activity affected by the disability. Describe how the physical or medical condition affects the student (e.g., allergy to peanuts causes a life-threatening reaction or diabetes and needs timed meals with insulin).

**11. Diet Plan and/or Accommodation:** Describe a *specific* diet ( or accommodation (e.g., soft foods) that has been prescribed by

a physician or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid  
or

pureed form; student cannot eat solid foods).

**12. Foods to be Omitted and Substitutions:** List specific foods that must be omitted (e.g., exclude fluid milk). If specific foods

do not need to be omitted, skip this question. **Suggested Substitutions:** List specific foods to include in the diet (e.g., calcium-fortified milk).

**13. Texture modification:** Check (✓) a box to indicate the type of texture accommodation of foods that is needed. If the

student does not need any texture modification, skip this question.

**14. Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., a sippy cup, a large handled spoon, suction plate).

**15. Additional Information:** List any other information related to meals or eating that might be helpful.

**16. Printed Name of Medical Authority:** Print the name of the medical authority.

**17. Telephone Number:** Print the telephone number with area code, of the medical authority. **18. Signature of Medical Authority:** Signature of the medical authority requesting a special meal or accommodation.

**19. Date:** Print the date the medical authority signed the form.

**20. Office Stamp of Medical Authority:** Must be completed by medical authority staff member and should include name of

medical practice, address and phone number

Florida Department of Agriculture and Consumer Services • Revised September 2025 • Page 3 of 4

**SUGGESTED FLOW FOR HANDLING MEAL MODIFICATION REQUESTS**

Parent or guardian makes a request  
to the school for a modified menu  
for the student.

School provides the parent or  
guardian with the Medical  
Statement for Meal Modification  
form and expectations.

Parent or Guardian has a medical  
authority\*\* complete the Medical

Statement for Meal Modification  
form and returns the signed form to

the school.

School: Does the child  
have a disability\* as stated

by a medical professional?

Yes                      No

School places the original form in School contacts the parent regarding

the student's health record and the non-disabling conditions.  
forwards a copy to food service to Implementation depends on the

be implemented immediately. school or school district's internal  
School contacts the parent policies.  
regarding approval.

\* Disability: a physical or mental impairment that substantially limits one or more major life activities including, but not limited to, seeing, hearing, walking, speaking, learning, reading, eating, breathing etc.

\*\* Medical Authority: a state licensed health care professional authorized to write medical prescriptions must sign this form.

Includes: Licensed Physicians (MD, DO), Advanced Registered Nurse Practitioners (ARNP), and Physician's Assistants (PA).