Food and Nutrition Services
Diocese of Lafayette
Medical Statement for Diet Modifications SY 2025-2026

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, Fresh Fruit and Vegetable Program (FFVP), and Child and Adult Care Food Program (CACFP) At-risk Supper Program implemented in schools. 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. For more information, please reference USDA's 2017 version of "Accommodating Children with Disabilities in the School Meal Programs." *It is Food and Nutrition Services Policy that this form be completed ANNUALLY.*

Section 1 – Completed by parent or guardian

School Child Attends: _____ Grade: _____
Name of child: _____ Birth date: _____
Name of parent or guardian: _____
Phone number (with area code): _____ E-mail address: _____
Signature of parent or guardian: _____ Date: _____

Section 2 – Completed by child's state-licensed healthcare professional (*Required)

This section must be completed by the child's *physician, physician assistant, or nurse practitioner*.

*Food ***Omission(s)***: List food(s) to be omitted from the child's diet: _____

_____

*Brief ***Explanation*** of how the exposure will affect the child: _____

_____

*Recommended ***Substitute(s)***: _____

_____

Comments: _____

_____

_____

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Section 3 – *If a disability does ***not*** concern a food allergy, please complete the following:

1. Does the student have the existence of a physical or mental impairment: _____
2. Describe the way in which the impairment impacts the student: _____
3. The food modification needed (i.e. texture, etc.):

_____

Section 4 – Signature

Name of state-licensed healthcare professional: _____

Phone number (with area code): _____

Signature of state-licensed healthcare professional: _____ Date: _____

Signature of FNS Director/Registered Dietitian approval: _____ Date: _____

Please upload via google forms at www.fns-dol.org or by using the QR code below. Email for support: nutrition@fns-dol.org

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Office of the Assistant Secretary for Civil Rights
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