July 1, 2020

Dear Parent/Guardian:

As part of the enrollment process, please review the *Medical Statement to Request School Meal Modification* form enclosed with this letter and have your student's medical authority (MD, DO, PA, APRN) complete. All completed forms must be returned to **Laine Norris, Director of Food and Nutrition Services located at 1511 Gypsum Ave.,** and must be received by **July 29** in order for Food and Nutrition Services to comply with your student's special dietary needs for the first day of school. Annual updates to special diet instructions are **required**.

Additionally, if dietary changes are necessary during the course of the school year, have your student's medical authority (MD, DO, PA, APRN) complete the *Medical Statement to Request School Meal Modification* form, and return the completed form to your **school's nurse**, who will then send the form to the Director of Food and Nutrition Services. Please note that if you are submitting a request for meal modification at a time other than the beginning of the school year, it may take up to ten school days from the time the request is received until it can be implemented.

If your student no longer requires special accommodations during the course of the school year, please complete the *Discontinuation of Meal Modification* form enclosed with this letter and return to your **school's nurse**, who will then send the form to the Director of Food and Nutrition Services. This form may be signed by either a Parent/Guardian or Medical Authority.

If you have questions or need assistance, please contact the Director of Food and Nutrition Services.

Respectfully,

Laine Norris

Laine Norris, MS, RD, LD
Director of Food and Nutrition Services
USD 305 Salina Public Schools
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Enclosures

This institution is an equal opportunity provider.

Medical Statement to Request Meal Modification

Modifications to Accommodate a Disability: Meal modifications prescribed by a medical authority must be made to accommodate a participant's disability.

Definition of Disability: Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. "Major life activities" are broadly defined and 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 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.

This form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (APRN) authorized by their responsible licensed physician.

Part A. Participant, Parent/Guardian, Facility Contact Information – To be completed by a parent/guardian or facility contact person.

Participant's Name:	Date of Birth:	Facility:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
Facility Contact's Name:	Facility Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Description of the physical or mental impairment related to the prescribed diet order and major life activity affected.
   Example: Allergy to peanuts affects ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

Modified Texture:	☐ Not Applicable	☐ Chopped	☐ Ground	☐ Pureed
Modified Thickness of Liquids:	☐ Not Applicable	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick
Special Feeding Equipment:	☐ Not Applicable	☐ Special Feeding Equipment ________________ (e.g. large handled spoon, sippy cup, etc.)		

3. Medical Authority's Information:

Signature:	Title:	
Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for facility personnel responsible for implementing the prescribed diet order to discuss the special dietary accommodations with any appropriate staff and to follow the prescribed diet order for meals. I also give permission for the medical authority to further clarify the prescribed diet order on this form if requested to do so by facility personnel.

Parent/Guardian's Signature: Date:

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USD 305 FOOD & NUTRITION SERVICES

Discontinuation of Meal Modification

Student's Name ____

School ____

I certify that the student named above is no longer in need of the previously prescribed meal modification effective on the date of this form.

____
Printed Name of Parent/Guardian OR Medical Authority

____ ____________
Signature of Parent/Guardian OR Medical Authority Date

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