St. Lucie Public Schools
Child Nutrition Services
How may we SERVE you

9461 Brandywine Lane
Port St. Lucie, FL 34986

Return to Cafeteria Manager
MUST BE SIGNED BY PHYSICIAN AND PARENT FOR ACCEPTANCE

Meal Modification Form for Special Dietary Accommodations SY 22/23

This form is for a request for a meal modification for special diets including food allergies. A physician completing this form confirms your student has a medical necessity for a modified diet (**NOT food preferences**).

Parent/Guardian: Complete Sections 1-4

1. Students Name: ____Student Lunch Number: ______________________

School Name: _____________________________ Grade: _______ Teacher: ________________ DOB: ______________

Mailing Address: ____ City: __________________ Zip: ____________

Parent/Guardian Name: ____

Phone Number (Home): _________________________________ Cell/Mobile: _________________________________

2. Check which meals student eats at school:
Breakfast Lunch Supper Snack Does not eat school meals

3. Parents may complete this section – form still needs to be signed by medical doctor.
Does student have intolerance to milk? Yes No Fluid Milk Only? Yes No
Circle if student can have: Yogurt Cheese Dairy in baked goods Pizza

4. **Medical Release statement:** I, ________________________ the parent/guardian of the student listed above consent to the release of pertinent dietary information between physician and school as needed to meet the dietary needs of student. All information will be kept confidential.

Physician name: ____ Physician phone: ___________________________
I acknowledge that my child may be identified in the school meal service line. ___________ Parent/Guardian Initial
Parent/Guardian Signature: ____ Date: ____________________

Instructions: All sections must be completed in full. Page two must be completed and signed by a Licensed Physician. Form must be returned to the Cafeteria Manager. Cafeteria Manager will review form. Incomplete form/blank sections will be returned to parent to complete. Once all sections are complete/signed, Manager will forward to Child Nutrition Services District Office for verification.
For questions or clarification on meal modifications please contact Jennifer Muzzin, RD - jennnifer.muzzin@stlucieschools.org

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Incomplete forms will be returned. Please do not leave any sections blank to avoid delays with processing

All sections below are to be completed by a Licensed Physician.

This section must be answered. Cannot be left blank.

Does the student have a Disability, Medical Condition (Diabetes, GI Disorder, Renal Disease), or Severe Food Allergy? Yes No

If yes, please provide a brief description of the major life activity (ex., breathing, learning, eating) affected by the disability or severe and/or life-threatening reaction resulting from the food allergy.

____
____
____

Circle all foods to omit for the student's diet during the school day only (not to be used as medical history):
Milk Egg Wheat Soy Peanut Tree Nut Fish Shellfish
Other (not listed above): ____

Foods to omit and suggested substitutes: (Attach additional sheet if needed).

Food(s) to omit	**Suggested Substitute(s)**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Diet Prescription: For carbohydrate or protein restrictions, include level (grams) for each meal.

____

Food Texture Modification (please circle):

IDDS foods EC7 – regular/easy to chew
IDDS foods 6 – soft & bite-sized
IDDS foods 5 – minced & moist
IDDS foods & drinks 4 – pureed/extremely thick
IDDS foods & drinks 3 – liquidized/moderately thick
IDDS drinks 2 – mildly thick
IDDS drinks 1 - thin
Thickener Recommend: ____________________

Physician Signature: ___________________________Date: _________ Physician's Stamp:
Physician Office Phone:_______________________________________
Physician Office Contact Person: _______________________________

To be completed by Child Nutrition Services (District Office Use Only)

Date received by Cafeteria Manager: ___________ Manager Name/School: ______________________________
Date received by District Office: ________________

Notes: