

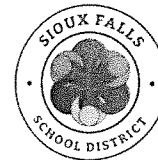
Central Services Center-Child Nutrition Services

1101 N Western Avenue

Sioux Falls, South Dakota 57104

(605) 367-7925 Fax (605) 367-7937

Dr. James Nold, Superintendent

**REQUEST FOR MEAL MODIFICATION DUE TO HEALTH CONDITION****Section 1: To be completed by parent**

School Name		Name of Participant/Child	
Date of Birth		Name of Parent /Guardian	
Parent/Guardian Phone Number		Parent/Guardian Email	
"If your child is not currently receiving/served under either an Individualized Education Plan (IEP) or a Section 504 plan, this request for a special diet will be considered a consent for a Section 504 evaluation."			
Parent/Guardian's Printed Name			
Parent/Guardian's Signature		Date	

Section 2: Must be completed by a licensed physician (MD or DO), physician's assistant (PA), nurse practitioner (NP), or registered dietitian (RD)

Describe the health condition of concern:			
Describe how the physical or mental condition/impairment(s) listed above restricts this child's diet.			
<input type="checkbox"/> Ingestion causes GI distress <input type="checkbox"/> Ingestion causes choking <input type="checkbox"/> Food/texture aversion <input type="checkbox"/> Limits ability to chew <input type="checkbox"/> Ingestion causes organ damage <input type="checkbox"/> Ingestion causes anaphylaxis <input type="checkbox"/> High caloric needs <input type="checkbox"/> Ingestion causes hives/rash <input type="checkbox"/> Other: _____			
If the impairment restricts specific foods, please specify below.			
Dairy/Eggs, please clarify: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Fluid Milk <input type="checkbox"/> All Dairy <input type="checkbox"/> Whole Eggs (ex. Scrambled, hard boiled, etc.) <input type="checkbox"/> All food with egg/egg derivatives </div> <div> <input type="checkbox"/> Sesame <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree Nuts (ex. almond, pecan, walnut, etc.) </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> <input type="checkbox"/> Soy <input type="checkbox"/> Wheat <input type="checkbox"/> Fish <input type="checkbox"/> Gluten <input type="checkbox"/> Shellfish <input type="checkbox"/> Other, please list: </div> <div> <input type="checkbox"/> Check this box if the participant <u>CANNOT</u> tolerate the selected food items BAKED in goods: Comments _____ </div> </div>			
If foods are to be eliminated from the diet, please recommend substitutions.			
Indicate texture consistency, if needed.		Indicate liquid consistency, if needed.	
<input type="checkbox"/> Mechanical Soft Solids & Chopped Meats <input type="checkbox"/> Fork Mashable Solids & Ground Meats <input type="checkbox"/> Pureed Solids & Meats <input type="checkbox"/> Other (Specify):		<input type="checkbox"/> Thin <input type="checkbox"/> Honey Thick <input type="checkbox"/> Nectar Thick <input type="checkbox"/> Pudding Thick	
Medical Professional's Printed Name			
Medical Professional's Signature		Date	

This School Agency Is An Equal Opportunity Provider