Colorado Springs School District 11
Food and Nutrition Services

5260 Geiger Blvd., Colorado Springs, CO 80915
Phone: 719-520-2923 Fax: 719-520-2935
http://www.d11.org/Page/2074

Special Dietary Needs

2019-2020 School Year

Dear Parent/Guardian:

Your child's school:

1. **Will** make meal modifications **prescribed by a licensed physician, advanced practice nurse with prescriptive authority, or physician's assistant** to accommodate a disability. Properly completed and signed paperwork is required.
2. **Will not** make school meal modifications for requests that do not rise to the level of a disability including;
   * Food sensitivity that can be accommodated through menu choices
     Note: Milk is not a required meal component and can be declined by any student.
   * Dietary preferences for religious, ethical, or cultural reasons, or general health concerns

A disability is considered a physical or mental impairment which substantially limits one or more major life activity.

It is strongly recommended that a recognized medical authority annually update the prescribed diet order.

If this is a life-threatening food allergy resulting in anaphylaxis, ensure the *Colorado Allergy and Anaphylaxis Emergency Care and Medication Orders* form is completed by a recognized medical authority for school nursing staff.

Return the completed *Medical Statement for School Meal Modification Form*
By mail or personal delivery to:
CSSD11 Food and Nutrition Services
5260 Geiger Blvd.
Colorado Springs, CO 80915
Or by fax: 719-520-2935

If you have questions or need assistance, please contact Jamie Humphrey, Administrative Dietitian at (719) 520-2924 or Jamie.Humphrey@d11.org.

Sincerely,

Jamie Humphrey, RDN
Colorado Springs School District 11
Food and Nutrition Services Department

Medical Statement for Dietary Disability School Meal Modification
form may be printed on back or attached separately.

2018-2019 Medical Statement for Dietary Disability School Meal Modification

Colorado Springs School District 11 Food and Nutrition Services Fax to: 719-520-2935

Part A. Student & School Contact Information – To be completed by a parent/guardian or school contact person

Student Name:		(Optional) School Contact Name:
Date of Birth:	Student ID #:	School Contact Phone:
School:	2019-2020 Grade:	School Contact Email:

Part B. Parent/Guardian Contact Information – To be completed by a parent/guardian or school contact person

Parent/Guardian 1 Name:	(Optional) Parent/Guardian 2 Name:
Parent/Guardian 1 Phone:	Parent/Guardian 2 Phone:
Parent/Guardian 1 Email:	Parent/Guardian 2 Email:
Home (Mailing) Address:	Colorado Springs, CO Zip Code:

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

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff. I also give permission for my child's Licensed Physician, Nurse Practitioner, or Physician Assistant to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: Date:

Part D. Prescribed Diet Order – To be completed by the appropriate recognized medical authority.

A disability is considered a physical or mental impairment which substantially limits one or more major life activity.

It is strongly recommended that a recognized medical authority annually update the prescribed diet order.

1. **Mechanical Modification:** ☐Check if Not Applicable Medical Condition/Reason for Modification: _____

☐ Modify Texture: ☐Chopped ☐Ground ☐Pureed

☐ Modify Consistency: ☐Nectar Thick ☐Honey Thick ☐Spoon or Pudding Thick

☐ Adaptive Equipment: (Specify) _____

2. **Nutrient Modification:** ☐Check if Not Applicable Medical Condition/Reason for Modification: _____

Example: Diabetes, phenylketonuria (PKU), etc.

Nutrient to modify _____ ☐Min ☐Max ☐Range _____ ☐mg ☐gm ☐mL ☐kcal per ☐Meal ☐Day

3. **Ingredient Modification:** ☐Check if Not Applicable

☐ Medical Condition: Severe Food Allergy/Anaphylaxis **Cross-contact precautions required.**

Omit: ☐Peanut ☐Tree Nut ☐Soy ☐ Wheat ☐Milk ☐Egg ☐ Fish ☐ Crustacean Shellfish

☐ _____

☐ Medical Condition: Celiac Disease **Cross-contact precautions required.**

Omit: Gluten (wheat, rye, barley, triticale, spelt, kamut, and derivatives, including barley malt)

Allowed: naturally Gluten Free foods (rice, corn, potato, etc.) and guaranteed Gluten Free oats and products

☐ Medical Condition/Reason for Modification: _____

Omit: _____

Indicate whole or partial ingredients to be eliminated. Example: lactose, egg yolk, or corn protein

Allowed: _____

Example: yogurt, eggs in bread/baked foods, corn starch, soy lecithin, or soybean oil not listed as an allergen

Recommended alternatives (if applicable):_____

Part E. Licensed Physician/ Advanced Practice Nurse with Prescriptive Authority / Physician Assistant Information

I certify the above named student needs special school meals as described above, due to the student's disability. Signature: Date: Printed Name/Credentials:	**Office Stamp (preferred) or Print:** Clinic: Address: City, ST, Zip: Phone: Fax: