

# Diet Modification Request

## Diet Modification Request for Foods Served Through Child Nutrition Programs of Washoe County School District

Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

District and/or school/site: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Does the patient have a disability as defined in Section 504 of the Rehabilitation Act of 1973 of the Americans with Disability Act and updates?

**YES = Disability-To be completed by licensed physician or recognized medical authority (Doctor of Medicine, Doctor of Osteopathy, Physician Assistant, or Advanced Practice Registered Nurse)**

Federal regulations governing the Child Nutrition Programs provide that schools/districts **must** make substitutions in meals for students who are considered to have a disability as defined by the Americans with Disability Act and whose disability restricts their diet when supported by a statement signed by a physician licensed by the state which includes all information in questions a and b below.

**Does the student have in IEP or 504 Plan in place?**  **Yes**  **No**  
If yes, is the following information below included in the IEP or 504 Plan? Yes  No

If yes, then the rest of the form does not need to be completed. The school/district may use the IEP or 504 Plan in lieu of this form and keep on file.

If no, the rest of the form must be completed.

a. **Description of child's physical or mental impairment (must be sufficient to allow school site/district to understand how it restricts child's diet):**

b. **What meal modifications are needed?** (e.g., texture changes and/or food item substitutions)

**Must** identify any foods to be omitted: (see back of page)

**Must** identify foods to be substituted/added:

Signature (recognized medical authority): \_\_\_\_\_ Date: \_\_\_\_\_

Please print name and title: \_\_\_\_\_

**NO = Medical condition, but not a disability – To be completed by recognized medical authority (Doctor of Medicine, Doctor of Osteopathy, Physician Assistant, or Advanced Practice Registered Nurse)**

A school/district, **at its discretion**, may make menu substitutions with a signed statement from a recognized medical authority for a student who is requesting a meal modification.

a. **Description of the child's physical or mental impairment (must be sufficient to allow school site/district to understand how it restricts your child's diet):**

b. **What diet modifications are requested?** (e.g., texture changes and/or food item substitutions)

List any foods to be omitted: (see back of page)

Foods to be substituted/added

Signature (recognized medical authority): \_\_\_\_\_ Date: \_\_\_\_\_

Please print name and title: \_\_\_\_\_

**Some common allergens with various ways they are found in foods.  
Please check the box in front of food groups that should NOT be served:**

**Lactose/milk – Do not serve the following checked items:**

- Fluid Milk to drink or use on cereal
- Milk based desserts such as: ice cream and pudding
- Hot entrees with cheese as a prime ingredient such as: grilled cheese, cheese pizza, or macaroni & cheese
- Cheese baked in products such as: a casserole or on meat pizza
- Cold cheese such as: string cheese or sliced cheese on a sandwich
- Milk in products such as: breads, mashed potatoes, cookies or graham crackers

**SERVE THESE ITEMS INSTEAD:**

¼ cup of fluid milk to be used on cereal? \_\_yes \_\_no

**Soy - Do not serve the following checked items:**

- Protein products extended with soy
- Processed items cooked in soy oil
- Food products with soy as an ingredient no matter where on the ingredient list
- Food products with soy listed as the fourth ingredient or further down the list

**SERVE THESE ITEMS INSTEAD:**

**Egg - Do not serve the following checked items:**

- Cooked eggs such as scrambled eggs or hard cooked eggs served hot or cold
- Eggs used in breading or coating of products
- Baked products with eggs such as breads or desserts

**SERVE THESE ITEMS INSTEAD:**

**Shellfish or fish – Do not serve the following checked items:**

- Specific fish or seafood type: \_\_\_\_\_

**SERVE THESE ITEMS INSTEAD:**

**Peanuts – Do not serve the following checked items:**

- Peanuts, individually or as an ingredient
- Foods containing peanut oil
- Foods items identified as manufactured in a plant that also handles peanuts

**SERVE THESE ITEMS INSTEAD:.**

**Tree nuts – Do not serve the following checked items:**

- Specify type(s): \_\_\_\_\_
- Foods items identified as manufactured in a plant that also handles nuts

**SERVE THESE ITEMS INSTEAD:.**

**Milk substitution for non-disability reasons (For a disability, the licensed physician must sign on front)**

A school/district, **at its discretion**, may make a **nutrient equal substitution** with a signed statement from a parent or medical provider for a student who is unable to consume fluid milk for any reasonable request that does not rise to a level of a disability.

\_\_\_\_\_ I request a substitute for fluid milk for my student.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

Questions? Please contact Tracey Marcum at tmarcum@washoeschools.net and/or 775-353-5246.  
Please return this form to the school Nurse or office to be forwarded to Child Nutrition/Food Service Department.

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To be kept on file in the Child Nutrition Services Office.  
Date received by Child Nutrition: \_\_\_\_\_

Is additional clarification needed on the medical statement? \_\_\_\_ Yes or \_\_\_\_ No. If yes, please indicate follow up here:  
\_\_\_\_ Initial \_\_\_\_ date

Date discontinued: \_\_\_\_\_ (Attach documentation)

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