



# Medical Statement for Students Requiring Special Meals or Accommodations

Instructions: Parent or Guardian should complete information in Section 1. Section 2 (shaded area) is to be completed by a MD, DO, RNP, or PA. Return completed forms to the Food and Nutrition Services Department. **This statement must be updated when there is a change or discontinuance of a diet order.**

<b>Section 1                    ** To Be Completed By the Parent/Guardian**</b>			
Student's Name		Birth Date	
Name of School	Grade	Classroom	
<b>My child no longer requires any diet modification</b> <input type="checkbox"/> _____ <div style="display: flex; justify-content: space-between;"> <span>Parent/Guardian Signature</span> <span>Date</span> </div>			
Is this request due to a religious or personal preference Yes <input type="checkbox"/> No <input type="checkbox"/>			
I hereby give permission for the school staff to follow the nutrition plan below. I give my permission for the School City of Hammond staff to contact the doctor named below with any questions related to my child's nutrition requirements and to share information with the appropriate school personnel.			
Parent/Guardian Signature _____		Date _____	
Daytime Phone _____		Home Phone _____	
<b>Section 2                    ** To Be Completed By MD, DO, RN Practitioner, or Physician Assistant**</b>			
<b>Is this child disabled?</b>			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If Yes</b> , describe the major life activities affected by the disability and requiring special nutritional or feeding needs.			
Describe the child's condition that requires a diet modification:			
Indicate foods to avoid and whether the condition is an allergy or food intolerance. If an allergy is indicated we will not serve the student any menu item containing the allergen (e.g., milk allergies will also eliminate cheese, ice cream, or any item containing these foods such as pizza, mashed potatoes, baked goods containing milk.).			
Milk intolerance <input type="checkbox"/> No fluid milk only (may have yogurt, cheese, and other dairy)			
Milk intolerance <input type="checkbox"/> No milk products (no fluid milk, yogurt, cheese, and dairy products)			
Milk intolerance <input type="checkbox"/> No milk products or products containing milk (e.g., mashed potatoes, baked goods that contain milk)			
Allergy <input type="checkbox"/> Food: _____ Requires Epi-Pen? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Allergy <input type="checkbox"/> Food _____ Requires Epi-Pen? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Allergy <input type="checkbox"/> Food: _____ Requires Epi-Pen? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Other diet modifications: _____ _____			
List foods/beverages to be omitted:			
List foods/beverages to be substituted:			



# Medical Statement for Students Requiring Special Meals or Accommodations

<b>Student:</b>	<b>School:</b>
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground: Pureed:	
Indicate any other comments:	
MD, DO, RNP, or PA Signature ( <b>Required for all disabilities</b> )	Date:
Physician Printed Name and Office Phone Number	
Medical Authority's Signature ( <b>Required for all other medically required modifications</b> )	Date:
Medical Authority's Printed Name and Phone Number	

Send completed and signed Diet Plan by mail, fax, or email to:

Department of Food and Nutrition  
41 Williams Street  
Hammond, IN 46320

**Email:** [crclarahan@hammond.k12.in.us](mailto:crclarahan@hammond.k12.in.us)

**Fax:** 219-554-4502

**If you have questions please contact:**

Christine Clarahan MS, SNS, RDN  
Director of Food & Nutrition  
Registered Dietitian Nutritionist  
219-933-2400  
[crclarahan@hammond.k12.in.us](mailto:crclarahan@hammond.k12.in.us)

School City of Hammond menus are posted on [www.SCHLunch.com](http://www.SCHLunch.com)

**This institution is an equal opportunity provider.**