METRO NASHVILLE PUBLIC SCHOOLS
NUTRITION SERVICES

MEDICAL STATEMENT FOR MEAL MODIFICATION

PART A: Student, Parent/Guardian, & School Contact Information—*To be completed by parent/guardian.*

Student Name: _____	**Date of Birth:** _____
Parent/Guardian Name: _____	**Parent/Guardian Phone:** _____
Reason for Request: ☐ **Life threatening food allergy** ☐ **Disability** ☐ **Other (specify):**_____	**School Name:** _____
Specify the student's medical needs and how this restricts his/her diet.	

PART B: Food Allergies/Intolerances/Dietary Restrictions— *To be completed by a recognized medical authority. Indicate the food items that must be omitted from school provided meals and list any food substitutions.*

◯ **Milk**	◯ **Shellfish**
◯ **Egg**	◯ **Soy**
◯ **Peanut**	◯ **Wheat**
◯ **Tree Nut**	◯ **Other:** _____
◯ **Fish**	

Comments/Specific instructions/Recommended food alternatives:

Food Texture Modifications—*To be completed by a recognized medical authority. Select the texture modification prescribed and specify which types of foods should be modified.*

☐ **Chopped** ☐ **Ground** ☐ **Pureed** ☐ **Not Applicable**

Comments/Specific Instructions:

Signature Required—*Fax completed form to MNPS Nutrition Services:* (615) 214-8853.

_____ **Physician/Medical Authority Signature**	**Office Phone Number:** _____ **Date:** _____

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1. mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;
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