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### Special Dietary Medical Statement Vermont Agency of Education Child Nutrition Programs

Date:

Child Name: \_\_\_\_\_

Parent/Guardian Name and Contact Information: \_\_\_\_\_

Does the child's IEP or 504 Plan contain the information required as outlined below?

Yes  No

If No, please continue to fill out the form. If Yes, stop here.

#### Meal Modifications Made Outside The Meal Pattern

(Accommodation that alters the USDA meal pattern)

Foods to be Avoided/Omitted:

\_\_\_\_\_

Brief explanation of how exposure to this food affects the child:

\_\_\_\_\_  
\_\_\_\_\_

Recommended Substitute to this Food:

\_\_\_\_\_  
\_\_\_\_\_

Modified Texture Needed:

Special Utensils Needed:

Tube Feeding Required:

Tracking Assistance:

Other Accommodations needed:

\_\_\_\_\_  
Signature of Licensed Medical Professional      Printed Name of Licensed Medical Professional

For additional information, please refer to Pages 14 & 15 of USDA-FNS Accommodating Children with Disabilities in the School Meals Programs: Guidance for School Food Service Professionals, *July 25, 2017*

This institution is an equal opportunity provider.