NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION

Medical Statement to Request School Meal Modification

Revised 05/2025

1. District/School	2. Site Name	3. Site Phone Number
4. Name of Child or Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Phone Number

8. How does the physical or mental impairment restrict the participant's diet? Briefly explain how exposure to this food/beverage affects the participant to ensure proper implementation.

9. Indicate Food Texture for the Above Child or Participant:

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

10. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions

If Dairy allergy, can the child eat the following:		*If Egg allergy, can the child eat the following:*	
1. Milk/Dairy products in baked goods?	Y or N	1. Eggs cooked in recipes?	Y or N
2. Milk/Dairy products like Mac & Cheese?	Y or N	2. Baked breads with egg ingredients?	Y or N
3. Yogurt?	Y or N	3. French Toast?	Y or N
4. Cheese?	Y or N	4. Foods with mayonnaise?	Y or N

11. Adaptive Equipment to be Used:

12. Meal Modifications must be requested by a State-Licensed Medical Professional or Registered Dietitian/Registered Dietitian Nutritionist (RD/RDN). The licensed healthcare provider must complete the section below.

Printed Name of Licensed Healthcare Professional*	**Title:** ☐ **Physician (MD)** ☐ **Physician's Assistant (PA)** ☐ **Nurse Practitioner (ARNP)** ☐ **Registered Dietitian** (RD/RDN)
Signature of Licensed Healthcare Professional*	**Medical Office Name and Address**
Date Signed	**Phone Number**

***For this purpose, a state-licensed healthcare professional in North Dakota is a licensed physician, a physician assistant, or a nurse practitioner. Per USDA memo SP 07-2025, the requirement to accept medical statements from a registered dietitian must be implemented by July 1, 2025.**

The information on this form should be updated as needed to reflect the participant's current medical and/or nutritional needs. Meal modifications will continue until the licensed healthcare professional requests that they be changed or stopped.

****If clarification is needed, the School should contact the family. Medical records or charts cannot be requested.**

This institution is an equal opportunity provider.

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.

2. **Site:** Print the name of the site where meals will be served.

3. **Site Phone Number:** Print the phone number of the site where the meal will be served.

4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.

5. **Age of Child or Participant:** Print the age of the child or participant. For infants, please use the date of birth.

6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.

7. **Phone Number:** Print the phone number of the parent or guardian.

8. **How does the physical or mental impairment restrict the participant's diet? Briefly explain how exposure to this food/beverage affects the participant.** Describe how the physical or mental impairment restricts the child or participant's diet, as prescribed by the state healthcare professional. The diagnosis is not required to be shared.

9. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".

10. **Other Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).
    For Dairy or Egg Allergies: Indicate the extent to which the child can eat (e.g., yes to eggs baked in products).

11. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheelchair-accessible furniture, etc.).

12. **Meal Modifications must be requested by a state-recognized Licensed Medical Professional or Registered Dietitian/Registered Dietitian Nutritionist. The healthcare provider must complete the section below.** The State of North Dakota recognizes Physicians, Physicians Assistants and Nurse Practitioners in signing prescriptions. This meal modification is a prescription for the participant. Please print the name of the state-licensed healthcare professional, check the box beside the licensure of the healthcare professional, sign and date the form, and provide the medical office name, address, and phone number to complete the form.

Citations are from Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and the ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.