Special Dietary Medical Statement
Vermont Agency of Education Child Nutrition Programs

Date: _____

Child Name: _____

Parent/Guardian Name: _____

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*