Colorado Military Academy

360 Command View
Colorado Springs, CO 80915
Phone: 719-576-9838
https://coloradomilitaryacademy.org/nurse/

Special Dietary Needs

Dear Parent/Guardian:
Your child's school:

1. **Will** make meal modifications **prescribed by a licensed physician, advanced practice nurse with prescriptive authority, or physician's assistant** to accommodate a disability. Properly completed and signed paperwork is required.
2. **Will not** make school meal modification for requests that do not rise to the level of a disability including:
   *Food sensitivity that can be accommodated through menu choices
   Note: Milk to not a required meal component and can be declined by any student
   *Dietary preferences for religious, ethical, or cultural reasons, or general health concerns

A disability is considered a physical or mental impairment which substantially limits one or more major life activities.

It is strongly recommended that a recognized medical authority annually update the prescribed diet order.

If this is a life-threatening food allergy resulting in anaphylaxis, ensure the *Colorado Allergy and Anaphylaxis Emergency Care and Medication Orders* form is completed by a recognized medical authority for school nursing staff.

Return the completed Medical Statement for School Meal Modification Form
By mail or personal delivery to:

Colorado Military Academy
Attn: Food and Nutrition Services
360 Command View
Colorado Springs, CO 80915

If you have any questions or need assistance, please contact Colonel Nicole Roberts, Executive Director or Roberts.n@cmacs.org.

Sincerely,

Lt Col. Nicole Roberts
Colorado Military Academy Executive Director
Phone: 719-576-9839 ext. 327
Email: Roberts.n@cmacs.org

Part A. Student & School Contact Information – To be completed by a parent/guardian or school contact person

Student Name:		(Optional) School Contact Name:
Date of Birth:	Student ID #:	School Contact Phone:
School:	2017-2018 Grade:	School Contact Email:

Part B. Parent/Guardian Contact Information – To be completed by a parent/guardian or school contact person

Parent/Guardian 1 Name:	(Optional) Parent/Guardian 2 Name:
Parent/Guardian 1 Phone:	Parent/Guardian 2 Phone:
Parent/Guardian 1 Email:	Parent/Guardian 2 Email:
Home (Mailing) Address:	Colorado Springs, CO Zip Code:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff. I also give permission for my child's Licensed Physician, Nurse Practitioner, or Physician Assistant to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: Date:

Part D. Prescribed Diet Order – To be completed by the appropriate recognized medical authority.

A disability is considered a physical or mental impairment which substantially limits one or more major life activity.

It is strongly recommended that a recognized medical authority annually update the prescribed diet order.

1. **Mechanical Modification:** ☐Check if Not Applicable Medical Condition/Reason for Modification: _____
   - ☐ Modify Texture: ☐Chopped ☐Ground ☐Pureed
   - ☐ Modify Consistency: ☐Nectar Thick ☐Honey Thick ☐Spoon or Pudding Thick
   - ☐ Adaptive Equipment: (Specify) _____

2. **Nutrient Modification:** ☐Check if Not Applicable Medical Condition/Reason for Modification: _____
   Example: Diabetes, phenylketonuria (PKU), etc.
   Nutrient to modify _____ ☐Min ☐Max ☐Range _____ ☐mg ☐gm ☐mL ☐kcal per ☐Meal ☐Day

3. **Ingredient Modification:** ☐Check if Not Applicable
   - ☐ Medical Condition: Severe Food Allergy/Anaphylaxis **Cross-contact precautions required.**
     Omit: ☐Peanut ☐Tree Nut ☐Soy ☐ Wheat ☐Milk ☐Egg ☐ Fish ☐ Crustacean Shellfish
     ☐ _____
   - ☐ Medical Condition: Celiac Disease **Cross-contact precautions required.**
     Omit: Gluten (wheat, rye, barley, triticale, spelt, kamut, and derivatives, including barley malt)
     Allowed: naturally Gluten Free foods (rice, corn, potato, etc.) and guaranteed Gluten Free oats and products
   - ☐ Medical Condition/Reason for Modification: _____
     Omit: _____
     Indicate whole or partial ingredients to be eliminated. Example: lactose, egg yolk, or corn protein
     Allowed: _____
     Example: yogurt, eggs in bread/baked foods, corn starch, soy lecithin, or soybean oil not listed as an allergen
     Recommended alternatives (if applicable): _____

Part E. Licensed Physician/ Advanced Practice Nurse with Prescriptive Authority / Physician Assistant Information

I certify the above named student needs special school meals as described above, due to the student's disability.	**Office Stamp (preferred) or Print:**
Signature: Date:	Clinic:
Printed Name/Credentials:	Address:
	City, ST, Zip:
	Phone:
	Fax:

This institution is an equal opportunity provider.