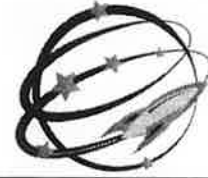


# Colorado Military Academy



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](mailto: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](mailto: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 #: 2017-2018 School Contact Phone:
School:	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: \_\_\_\_\_  
 Nutrient to modify \_\_\_\_\_  Min  Max  Range \_\_\_\_\_  mg  gm  mL  kcal per  Meal  Day  
*Example: Diabetes, phenylketonuria (PKU), etc.*

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed Name/Credentials: \_\_\_\_\_

Office Stamp (preferred) or Print:  
 Clinic:  
 Address:  
 City, ST, Zip:  
 Phone:  
 Fax: