Request for **Meal Modification**

What is considered a meal modification?

Food(s) to be substituted; Food(s) to be omitted/avoided from the child's diet

What is considered a milk replacement? *Lactose free milk &/or soy milk*

Student Name:_________________________ Birth Date:____________ Grade:__________

Parent/Guardian Name:____

Phone:_________________________ Email:___________________________________

Mailing Address:____

Signature of Parent/Guardian________________________________ Date:____________

Requirements:

The request for meal modification must include:

- Food(s) to be omitted/avoided from the child's diet
- How the ingestion of the food impacts the child
- Food(s) to be substituted

*Request for meal modification must be signed by a State-Recognized Medical Authority, a licensed health-care professional authorized to write medical prescriptions in Washington. *Also acceptable is a doctor's note answering the questions on this form.*

State-Recognized Medical Authority must complete and sign this section.

1.) Describe how the impairment affects the child (i.e., how the ingestion/contact with the food impacts the child):

2.) Explain what must be done to accommodate the child's diet (i.e., specific food(s) to be omitted/avoided from the child's diet):

3.) List food(s) and/or beverages to be substituted, provided, or modified:

Signature of State-Recognized Medical Authority:___________________________Date:_______

**State-Recognized Medical Authority is a licensed heath care professional authorized to write medical prescriptions in Washington State.*