Pittsylvania County Schools

School Nutrition Program

Dietary Modification
Medical Statement Form

Instructions: This form must be completed and signed by a licensed healthcare professional, such as a licensed physician, physician assistant, or nurse practitioner. The school/division may contact the licensed healthcare professional for clarification of information provided on this form. Return this form to your child's school.

Child's name: ________________________________ Child's date of birth: ________________

Name of School: ______________________________ Grade level/classroom: _______________

Name of Parent/Guardian: ____

Phone Number of Parent/Guardian: ____

Provide an explanation of how the student's physical or mental impairment restricts their diet:

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Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the student's needs: ____

List the food to be omitted (please be specific) and recommended alternatives, if appropriate.
Foods to be omitted: ____

Suggested substitutions: ____

Indicate texture modifications, if applicable:
• Chopped/Cut into bite sized pieces; • Ground/Finely Ground; • Pureed; • Other _____________

List any required special adaptive equipment: ____

Signature of licensed healthcare professional[1] ____

[1]*A licensed healthcare professional in the state of Virginia is defined as a licensed physician, physician assistance, or nurse practitioner.*

Printed name and title of licensed healthcare professional: _______________________________

Provider phone number: ____

Date: ____

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

______________________________________ ______________________________________

Signature of Parent/Guardian Date:

This institution is an equal opportunity provider. SY 2023-2024