Anoka-Hennepin Schools

DIET MODIFICATION REQUEST
Special Diet Statement for Participant with a Disability or Allergies

Part A

Student's Name	DOB	
Name of School	Grade Level	Date:

Part B

The remainder of the form must be completed by the licensed healthcare provider and signed below.

Food or Allergen to be Avoided or Disability*

Explain **how the exposure and/or disability would affect the student. ***

Describe the **major life activities affected by the disability**:*

List the food items to be **substituted** to replace the omitted food items:*

Indicate any other comments about the child's eating or feeding patterns.

Physician's Name (please print)	Clinic Name:
Physician's Signature (Licensed Physician, DO, Physician Assistant, Nurse Practitioner)	Date:

Physician/Clinic Phone Number:

Parent/Guardian Name (please print)

Parent/Guardian Signature	Date:

Parent/Guardian Preferred Contact Number:

NOTE: Sections with an * must be completed per the State of Minnesota requirements.

Return to one of the following for approval:

CNP Administrator (fax#763-506-1253 or 2727 North Ferry St., Anoka, MN 55303)
Form may also be submitted to the School Registered Nurse or school CNP Site Supervisor.

Time required for approval of the request is dependent upon time of year, completeness of the form and complexity of the diet.

Dev. 7/09, Rev 8/10, rev. 2/16 , 4/19 ,11/22