Anoka-Hennepin Schools

DIET MODIFICATION REQUEST

Special Diet Statement for Participant with a Disability

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

The remainder of the form must be completed by an authorized medical authority and signed below.**
(**Licensed Physician, Physician Assistant, Advanced Practice Registered Nurse or a Registered Dietitian)

REQUIRED INFORMATION*
(This information is required by the State of Minnesota and USDA. Incomplete forms will be returned for the required information)

Identify how the participant's physical or mental impairment affects their diet: *

Describe what must be done to accommodate the participant's dietary needs: *

If specific foods should be avoided, list those below: *
(Do not list specific brand names)

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

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

Providers: Please refer to IDDSI guidelines for texture modification guidance.

Authorized Medical Authority's Name (please print)	Clinic Name/ Phone Number:
Authorized Medical Authority's Signature (Licensed Physician, DO, Physician Assistant, Nurse Practitioner or Registered Dietitian)	Date:

Parent/Guardian Name (please print)

Parent/Guardian Signature Date:	Phone Number:

Return to one of the following for approval:
CNP Administrator (fax#763-506-1253 or 2727 North Ferry St., Anoka, MN 55303) OR
School Registered Nurse or school CNP Site Supervisor.
Time required for approval of the request may be delayed due to the complexity of the modification or missing required information.

This institution is an equal opportunity provider

Rev: 7/25

Updates to this form are required only when a participant's needs change.

ANOKA-HENNEPIN SCHOOLS
A future without limits