2025-2026 Meal Modifications Information Letter

Name: _____

Address: _____

Phone: _____ Fax: _____

Date_____

Dear Parent/Guardian:

Your child's health is very important to us. The USDA Breakfast and Lunch Program regulations require that meals offered in the schools meet the required meal patterns. Food substitutions may be made for medical needs on a case-by-case basis if supported by a statement signed by a recognized medical authority. A recognized medical authority may include physicians, physician assistants, or nurse practitioners. The attached "Authorization for Meal Modification Form" contains the required information needed to accommodate your child. Please have your medical authority complete and return to our school for the school nurse to keep on file:

_____

Once on file the school nurse gives this information to the Solvay UFSD Food Service Department. The Solvay UFSD Food Service Department utilizes the Offer vs. Serve meal service at our elementary schools, middle and high schools (Pre-K not included). This means your child may be able to make safe choices for his meal that are already on the menu. Parents and students are able to view the menus on the Solvay UFSD School District web page. Our school dietitian is available to work with families and students to reasonably accommodate your child's dietary needs. The attached form will stay on file until we receive written notification from the parent to remove. We look forward to working with you and your child. Feel free to call if you have any questions at_____.

Healthy Regards,

Michael Herr

2025-2026 Authorization for Meal Modification Form

Name: _____

Address: _____

Phone: _____ Fax: _____

AUTHORIZATION FOR MEAL MODIFICATIONS

Student Information (required):

Name _____ Date of Birth _____

School_____ Address _____

City _____ State _____Zip _____

MEDICAL REASON FOR MODIFICATION (required) _____

Foods to be omitted by the Food Service Department due to health issue (required):

_____

_____

Recommended alternate foods (school dietitian available to coordinate):

_____

_____

How often will child eat at school:

_____

Parent/Guardian Signature (required)

_____

Printed Name: _____

Date: _____

Telephone #_____

Medical Authority Signature (required)

_____

Printed Name: _____

Date: _____

Title: _____

Telephone: _____

Fax: _____

Address: _____

City _____ State _____Zip _____