# MEDICAL STATEMENT TO REQUEST

**SPECIAL MEALS AND/OR ACCOMMODATIONS OUTSIDE OF MEAL PATTERN**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.  school name** | | | | | | **2. site telephone number** | | |
| **3. name of participant** | | | | | | **4. age or date of birth** | | |
| **5. name of parent or guardian** | | | | | | **6.  telephone number** | | |
| **7. By checking the box, I affirm the statement below**     The student has a disability or a medical condition and is requesting a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician, physician’s assistant or an advanced registered nurse practitioner must sign this form.** | | | | | | | | |
| **8. disability or medical condition requiring a special meal or accommodation:** | | | | | | | | |
| **9. if the student has a disability, provide a brief description of participant’s major life activity affected by the disability:** | | | | | | | | |
| **10. diet prescription and/or accommodation: *(please describe in detail to ensure proper implementation)*** | | | | | | | | |
| **11. indicate NEEDED TEXTURE MODIFICATION**   N/A  Ground  Soft  Pureed  Liquid | | | | | | | | |
| **12. foods to be omitted and substitutions: *(please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information)***  **a. Foods To Be Omitted** **b. Suggested Substitutions** | | | | | | | | |
|  |  | |  |  | | | |  |
|  | |  | | | |
|  | |  | | | |
| **13. adaptive equipment:** | | | | | | | | |
| **14. Parent or guardian signature** | | **15. printed name** | | | | | **16. date** | |
| **17. medical authority\* Signature** | | **18. printed name** | | | **19. telephone number** | | **20. date** | |

**\* Medical authority includes a licensed physician, physician’s assistant, or an advanced registered nurse practitioner.**

**INTERNAL USE ONLY:**

|  |  |  |
| --- | --- | --- |
| **Date Received by School:** | **Date Placed in Student Health Record:** | **Date Copy Given to Food Services:** |
| **Recipients Signature:** | **Filer’s Signature** | **Recipients Signature:** |

**Meal modifications will be made as soon as possible.**

The USDA is an equal opportunity provide and employer.

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**SPECIAL MEALS AND/OR ACCOMMODATIONS OUTSIDE OF MEAL PATTERN**

**INSTRUCTIONS**

1. **School Name:** Print the name of the school that is providing the form to the parent.

2. **School Telephone Number:**Print the telephone number of the school.

3. Student **Name:** Print the name of the student to whom the information pertains.

4. **Age or Date of Birth:**Print the age of the student. For infants, please use date of birth.

5. **Parent or Guardian Name:** Print the name of the person requesting the student’s medical statement.

6. **Telephone Number:**Print the telephone number of parent or guardian.

7. **Check:** Check (🗸) box to indicate participant has a disability or medical condition.

8. **Disability or Medical Condition Requiring a Special Meal or Accommodation:**Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)

9. **If the student has a Disability, Provide a Brief Description of Participant’s Major Life Activity Affected by the Disability:**Describe how physical or medical condition affects disability. For example: ”Allergy to peanuts causes a life-threatening reaction.”

10. **Diet Prescription and/or Accommodation:**Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example:”All foods must be either in liquid or pureed form. Participant cannot consume any solid foods.”

11. **Indicate Needed Texture Modification:** Check (🗸) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check “N/A”.

12. **a. Foods to Be Omitted:** List specific foods that must be omitted. For example, the “exclude fluid milk.”

**b. Suggested Substitutions:** List specific foods to include in the diet. For example, “calcium fortified juice.”

13. **Adaptive Equipment:**Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)

14 **Parent or Guardian** **Signature:**Signature of person completing form.

15. **Printed Name:**Print name of person completing form.

16. **Date:**Date preparer signed form.

17. **Medical Authority Signature:**Signature of a licensed physician, physician’s assistant or an advanced registered nurse practitioner requesting the special meal or accommodation.

18. **Printed Name:**Print name of medical authority.

19. **Telephone Number:**Telephone number of medical authority.

20. **Date:** Date medical authority signed form.

**DEFINITIONS\***

**“A Person with a Disability”** is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

**“Physical or mental impairment”**means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito‑urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

**“Major life activities”**  are functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

**“Has a record of such an impairment”** is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

**(\*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990))**