MEDICAL STATEMENT TO REQUEST SPECIAL MEALS OR ACCOMMODATIONS

1. School or Agency: Click here to enter text.
2. Site Name: Click here to enter text.
3. Site Phone Number: Click here to enter text.
4. Name of Child or Participant: Click here to enter text.
5. Age or Date of Birth: Click here to enter text.
6. Name of Parent or Guardian: Click here to enter text.
7. Phone Number: Click here to enter text.
8. Description of Child or Participant's Physical or Mental Impairment Affected: Click here to enter text.
9. Explanation of Diet Prescription or Accommodation to Ensure Proper Implementation: Click here to enter text.
10. Indicate Food Texture for Above Child or Participant: ☐**Regular** ☐**Chopped** ☐**Ground** ☐**Pureed**
11. Foods to be Omitted: Click here to enter text.
12. Appropriate Suggested Substitutions: Click here to enter text.
13. Adaptive Equipment to be Used: Click here to enter text.
14. Signature of State Licensed Healthcare Professional*:
15. Printed Name: Click here to enter text.
16. Phone Number: Click here to enter text.
17. Date: Click here to enter text.

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

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1. Mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410

2. Fax: 202-690-7442

3. Email: program.intake@usda.gov

This institution is an equal opportunity provider.

The information on this form should be updated to reflect the current medical or nutritional needs of the participant.

INSTRUCTIONS

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

2. **Site:** Print the name of the site where meals will be served.

3. **Site Phone Number:** Print the phone number of the site where meals will be served.

4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.

5. **Age of Child or Participant:** Print the age of the child or participant (for infants, please use date of birth).

6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.

7. **Phone Number:** Print the phone number of parent or guardian.

8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.

9. **Explanation of Diet Prescription or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

10. **Indicate Texture:** If the child or participant does not need any modification, check **Regular**.

11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).

12. **Suggested Substitutions:** List specific foods to include in the diet (e.g., calcium-fortified juice).

13. **Adaptive Equipment to Use:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

14. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

15. **Printed Name:** Print name of state licensed healthcare professional.

16. **Phone Number:** Phone number of state licensed healthcare professional.

17. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

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; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

Has a record of such an impairment means a person has or has been classified (or misclassified) as having a history of mental or physical impairment that substantially limits one or more major life activities.