MEDICAL STATEMENT TO REQUEST SPECIAL MEALS OR ACCOMMODATIONS

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

***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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

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.