MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. District	2. School	3. School Telephone Number
Santa Ana USD		

4. Name of Student	5. Student ID #:	6. Date of Birth	7. Grade:

8. Name of Parent or Guardian	9. Telephone Number	10. Meals Needed:
		☐ Breakfast ☐ Lunch ☐ Snack

11. Check One:

☐ Participant does not have a disability **(A licensed physician, physician's assistant, or nurse practitioner must sign this form)**, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests.

☐ Participant has a disability or a medical condition (**A licensed physician must sign this form AND provide appropriate meal substitutions**) and *requires* 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.

12. Disability or medical condition requiring a special meal or accommodation:

13. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation-use extra pages as needed*)

14. Are texture modifications required:	15. Adaptive Equipment:
☐ Soft ☐ Chopped ☐ Ground ☐ Pureed	
16. Is the condition life threatening: ☐ Yes ☐ No	**17. Epi-Pen Prescribed:** ☐ Yes ☐ No

18. Attach a copy of special diet OR list food allergies/intolerances below:

OMIT:	SUBSTITUTE:
☐Fluid Milk To Drink, ☐All Foods Containing Milk (cheese, yogurt), ☐All Baked Products Containing Whey & Casein	☐Soy, Rice, ☐ Lactose-Free Milk, ☐Juice with Calcium, ☐Juice
☐Whole Eggs, ☐Egg Yolk, ☐Egg Whites, ☐All Products Containing Eggs	☐Beef, ☐Poultry, ☐Fish, ☐Beans, ☐Peanut Butter, ☐ Cheese, ☐Yogurt, ☐Egg-Free Breads/Crackers
☐Whole Wheat Products, ☐All Products Containing Gluten (wheat, rye, barley)	☐White Enriched Products, ☐Wheat-less Bread Products
☐Peanuts, ☐Tree Nuts, (Walnuts, Cashews), ☐ ALL NUTS	☐Beef, ☐Poultry, ☐Fish, ☐Beans, ☐Cheese, ☐Yogurt, ☐Eggs
☐Soy Beans, ☐All Soy Ingredients	☐Soy-Free foods with comparable nutrient value
☐Shellfish, ☐All Fish	☐Beef, ☐Poultry, ☐ Beans, ☐Peanut Butter, ☐Cheese, ☐Yogurt
☐Citrus Fruit, ☐Strawberries, ☐Other	Please Specify:

SUBSTITUTE: (Please Note: Juice is not an approved substitute for Milk under USDA guidelines)

_____

_____

19. Signature of Preparer*	20. Printed Name	21. Telephone Number	22. Date
23. Signature of Medical Authority*	**24. Printed Name**	**25. Telephone Number**	**26. Date**

*** Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.**

This form must be updated **annually** to reflect the current medical and/or nutritional needs of the student.

District Use ONLY: (Initial below to confirm receipt)

Nutrition Manager/Specialist _____ School Nurse _____ Cafeteria Supervisor _____

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **District/Agency:** Print the name of the school district that is providing the form to the parent.
2. **School:** Print the name of the site where meals will be served (e.g., school site, child care center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Student Identification Number:** Print student's ID number.
6. **Age of Participant:** Print the age or date of birth of the participant. For infants, please use Date of Birth.
7. **Grade:** Print student's grade level for current school year.
8. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
9. **Telephone Number:** Print the telephone number of parent or guardian.
10. **Meals Needed:** Please check (✓) the meals that the student will eat at school on a daily basis.
11. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
12. **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.)
13. **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."
14. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, please skip this box.
15. **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.)
16. **Is the condition life threatening:** Check (✓) yes or no.
17. **Is Epi-Pen prescribed:** Check (✓) yes or no.
18. A. **Foods to Be Omitted:** List or check (✓) specific foods that must be omitted.
    B. **Suggested Substitutions:** List or check (✓) specific foods to include in the diet.
19. **Signature of Preparer:** Signature of person completing form.
20. **Printed Name:** Print name of person completing form.
21. **Telephone Number:** Telephone number of person completing form.
22. **Date:** Date preparer signed form.
23. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
24. **Printed Name:** Print name of medical authority.
25. **Telephone Number:** Telephone number of medical authority.
26. **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" 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.

"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)