

**MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR
ACCOMMODATIONS
CHILD NUTRITION PROGRAMS**

INSTRUCTIONS

Note: According to 7 CFR, part 226.20 food substitutions for medical reasons can be made only when there is a written statement from a medical authority. This written statement must include the medical reason and recommended alternate foods.

1. **School/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 (e.g., school site, child care center, community 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. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person completing the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition is affected by the 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 Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
- 12A. **Foods to Be Omitted:** List specific foods that must be omitted. For example, "exclude peanut butter."
- 12B. **Available/Acceptable Substitutions:** List the available or acceptable substitution foods to include in the diet. For example, "sunflower seed spread."
13. **Modifications to Meal Service:** Describe specific equipment required, or modifications necessary to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, one-on-one support, etc.)
14. **Signature of Preparer:** Signature of person completing form.
15. **Printed Name:** Print name of person completing form.
16. **Telephone Number:** Telephone number of person completing form.
17. **Date:** Date preparer signed form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
19. **Printed Name:** Print name of medical authority.
20. **Telephone Number:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

The American with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. **(For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act Amendments Act of 2008).** Information regarding the ADAAA, which expanded the definition of disability, can be found at: <http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf>

MEDICAL STATEMENT TO REQUEST CHILD NUTRITION PROGRAMS SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number					
4. Name of Participant		5. Age or Date of Birth					
6. Name of Parent or Guardian		7. Telephone Number					
<p>8. Check One:</p> <p><input type="checkbox"/> Participant has a disability, which may include a food allergy, and requires a special meal or accommodation. Schools and agencies must make reasonable modifications to the meal to accommodate a disability which restricts a participant's diet. Modifications during and for food service may be required. Schools and agencies participating in federal nutrition programs must comply with requests for special meals. A licensed physician, physician's assistant, or nurse practitioner must sign this form.</p> <p><input type="checkbox"/> Participant does not have a disability, but is requesting a special accommodation for a fluid milk substitute that meets the nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, nurse practitioner, parent, or guardian may sign this form.</p>							
9. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:							
10. Diet prescription and/or accommodation: <i>(please describe in detail to ensure proper implementation-use extra pages as needed)</i>							
<p>11. Indicate texture:</p> <p><input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed</p>							
<p>12. Schools and agencies are not required to provide the exact substitution or other modification requested. However, must offer a reasonable modification that effectively accommodates the participant's disability and provides equal opportunity to participate in or benefit from the federal nutrition programs.</p> <p>Foods to be omitted and available/acceptable substitutions: <i>(please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed)</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;">A. Foods To Be Omitted</td> <td style="width: 50%; vertical-align: top; padding: 5px;">B. Available/Acceptable Substitutions</td> </tr> <tr> <td style="border: none;"> <hr/><hr/><hr/><hr/> </td> <td style="border: none;"> <hr/><hr/><hr/><hr/> </td> </tr> </table>				A. Foods To Be Omitted	B. Available/Acceptable Substitutions	<hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/>
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13. Modifications to meal service:							
14. Signature of Preparer*	15. Printed Name	16. Telephone Number	17. Date				
18. Signature of Medical Authority**	19. Printed Name	20. Telephone Number	21. Date				

*Parent/legal guardian signature is acceptable for fluid milk substitution for a child with dietary needs other than a disability.

**Medical Authority's signature is required for participants with a disability.

This institution is an equal opportunity provider.