Child Nutrition Programs
Medical Statement to Request Special Meals and/or Accomodations

Please return form to School Nurse

*Form must be signed by state recognized medical professional with prescriptive authority such as; licensed physician, physician's assistant, or nurse practitioner. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.

1. School/Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Participant		5. Age or Date of Birth

6. **I certify that the above-named student needs special school food as described on this form,**

Parent/Guardian Name(printed)_____ Signature_____

Phone Number_____ Email Address_____ Date_____

Section B - Must be completed by the Medical Practitioner (licensed physician, physician's assistant, or nurse practitioner)

Does the student have food allergies? ☐ Yes ☐ No

If yes, please select the allergen(s) from the list below:

Wheat
- ☐ All wheat
- ☐ All gluten (includes barley and rye)

Eggs
- ☐ All Egg Proteins - Albumin (whites) and yolk
- ☐ Whole Egg - Hard boiled and scrambled
- ☐ Eggs baked in products are ok (i.e. muffins)

Dairy
- ☐ All Milk Proteins - Casein, whey, etc.
- ☐ Fluid Milk
- ☐ Cheese
- ☐ Yogurt

Sesame
- ☐ All Sesame

Tree Nuts
- ☐ All Tree Nuts (including coconuts)
- ☐ All Tree Nuts (not including coconuts)

Peanuts
- ☐ All peanuts

Soy
- ☐ All Soy Protein
- ☐ All Soy Protein, except Soybean oil and Soy lecithin

Fish
- ☐ All fish

Shellfish
- ☐ All shellfish

Other: _____

Specific Foods to Omit or Substitute:

_____

7. Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

8. Adaptive Equipment to be Used:

9. Explanation of Child's Physical or Mental Impairment Affected:

_____

_____

10. Explanation of Diet Prescription and/or Accomodation to Ensure Proper Implementation (please describe in detail):

_____

_____

_____

11. I certify that the above-named student needs special school food as described above,

Medical Practitioner's Name_____ Office Phone Number_____

Medical Practitioner's Signature_____ Date_____

Child Nutrition Programs
Medical Statement to Request Special Meals and/or Accomodations

A recognized Medical Authority must fill out a Medical Statement to Request Special Meals and/or Accommodations form and return it to the school, child or adult care facility/provider. Agencies have an obligation to provide alternate foods to those participants who meet any of the following definitions.

Definitions:

"A person with a disability" is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such 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, specific learning disabilities.

"Major life activities" are defined as "functions such as 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, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions."

"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.

"Recognized Medical Authority" means state recognized medical professional with prescriptive authority such as, licensed physician, physician's assistant, or nurse practitioner.

The medical statement shall identify:

- The participant's disability or medical condition with an explanation of why the disability restricts the participant's diet;
- The major life activity affected by the disability;
- The specific diet or accommodation that has been prescribed by the medical authority. For example: "All foods must be in liquid or pureed form. Participant cannot consume any solid foods."
- The type of texture of food that is required,
- The specific foods that must be omitted and suggested substitutions
- The specific equipment required to assist the participant with dining. Examples might include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

Request for Special Meals and/or Accomodations
INSTRUCTIONS

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. Parent or Guardian Information: Provide the printed name, signature, phone number, and email address of the person requesting the participant's medical statement. Print the date.
Section B. Must be completed by Medical Practitioner (licensed physician, physician's assistant, or nurse practitioner)
Check (√) all boxes that apply and print any specific foods to omit or substitute.
7. 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".
8. Adaptive Equipment to be Used: Describe specific equipment required to assist the participant with dining. (e.g., a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
9. Description of Child's Physical or Mental Impairment Affected: Describe how the physical or mental impairment restricts the child's diet.
10. Explanation of Diet Prescription/Accommodation: Please describe in detail to ensure proper implementation (use extra pages as needed)
11. Signature of Medical Authority: Printed name, signature, and office phone number of medical authority requesting the special meal or accommodation. Print the date.

The American with Disabilities Act Amendment Act defines a "disability", in part, as a physical or mental impairment that substantially limits a 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

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

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

Request for Special Meals and/or Accomodations
INSTRUCTIONS CONT…

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

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

fax: (833) 256-1665 or (202) 690-7442; or

email: program.intake@usda.gov

This institution is an equal opportunity provider.