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

8. Check One:

☐ 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.**

☐ 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.**

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: (*please describe in detail to ensure proper implementation-use extra pages as needed*)

11. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

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.

Foods to be omitted and available/acceptable substitutions: (*please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Available/Acceptable Substitutions

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.**

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

This institution is an equal opportunity provider.

MA ESE July 2019/USDA June 2017