

Medical Statement to Request Special Meals and/or Accommodations

1. School District	2. School Name	3. Site Phone Number																		
4. Name of Child	5. Student ID#	6. Date of Birth																		
7. Name of Parent/Guardian		8. Phone Number																		
9. Description of Child's Physical or Mental Impairment Affected:																				
10. Explanation of Diet Prescription and/or Accommodation:																				
11. Indicate When Special Meals Are Needed: ☐ School Breakfast ☐ School Lunch ☐ Special Meal is Not Needed																				
12. Indicate Food Texture for Above Child: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed																				
13. Adaptive Equipment to be Used:																				
14. Foods to be Omitted and Appropriate Substitutions: <table><thead><tr><th>Foods to Be Omitted</th><th>Suggested Substitutions</th></tr></thead><tbody><tr><td>☐ Fluid Milk to Drink ☐ All Dairy Products (cheese/yogurt/milk)</td><td>_____</td></tr><tr><td>☐ Wheat/Gluten ☐ All Items Containing Milk as an Ing.</td><td>_____</td></tr><tr><td>☐ Whole Eggs ☐ All Items Containing Eggs as an Ing.</td><td>_____</td></tr><tr><td>☐ Peanuts ☐ Tree Nuts</td><td>_____</td></tr><tr><td>☐ Whole Soy (i.e.tofu) ☐ All Items Containing Soy as an Ing.</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr></tbody></table>			Foods to Be Omitted	Suggested Substitutions	☐ Fluid Milk to Drink ☐ All Dairy Products (cheese/yogurt/milk)	_____	☐ Wheat/Gluten ☐ All Items Containing Milk as an Ing.	_____	☐ Whole Eggs ☐ All Items Containing Eggs as an Ing.	_____	☐ Peanuts ☐ Tree Nuts	_____	☐ Whole Soy (i.e.tofu) ☐ All Items Containing Soy as an Ing.	_____	_____	_____	_____	_____	_____	_____
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15. Signature of Registered Dietitian (RD) or State Licensed Healthcare Professional*																				
16. Printed Name	17. Phone Number	18. Date																		

* In California, effective April 1, 2025, RDs are permitted to complete and sign a written medical statement for school meal modifications due to a disability. The CDE also permits the following state licensed healthcare professionals to complete and sign a written medical statement for a disability: licensed physicians, physician assistants, and nurse practitioners.

This form is also considered valid with a certified digital signature.

The information on this form is required to reflect the current medical and/or nutritional needs of the child.

Instructions

1. **School District:** Print the name of the school that is providing the form to the parent/guardian.
2. **School Name:** Print the name of the site where meals will be served.
3. **Site Phone Number:** Print the phone number of site where meal will be served.
4. **Name of Child:** Print the name of the child to whom the information pertains.
5. **Student ID #:** Print the 10-digit Student ID # of the child
6. **Date of Birth of Child:** Print the date of birth of the child.
7. **Name of Parent/Guardian:** Print the name of the person requesting the child's medical statement.
8. **Phone Number:** Print the phone number of parent/guardian.
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 and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by the state licensed healthcare professional.
11. **Indicate Participating School Meal Services:** If the child does not require a special meal, check "Special Meals Are Not Needed"
12. **Indicate Texture:** If the child does not need any modification, check "Regular".
13. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child with dining (e.g., sippy cup, large handled spoon, wheelchair accessible furniture, etc.).
14. **Foods to be Omitted:** List specific foods that must be omitted.
Suggested Substitutions: List specific foods to include in the diet.
15. **Signature of RD or State Licensed Healthcare Professional:** Signature of RD or state licensed healthcare professional requesting the special meal or accommodation.
16. **Printed Name:** Print name of state licensed healthcare professional.
17. **Phone Number:** Phone number of state licensed healthcare professional.
18. **Date:** Date state licensed healthcare professional signed the form.

Definitions

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

Physical or mental impairment means, any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disability.

Physical or mental impairment includes, but is not limited to, contagious and noncontagious diseases and conditions such as the following: orthopedic, visual, speech, and hearing impairments, and cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional illness, dyslexia and other specific learning disabilities, Attention Deficit Hyperactivity Disorder, Human Immunodeficiency Virus infection (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working; and the operation of a major bodily function.

Major bodily function includes, the operation and functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems. The operation of a major bodily function includes the operation of an individual organ within a body system.

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Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027at:

<https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, found online at How to File a Program Discrimination Complaint 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, Mail Stop 9410, Washington, D.C. 20250-9410;
2. fax: 202-690-7442; or
3. email: Program.Intake@usda.gov.

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