

## MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Return Completed Form to the School Front Office

<b>1. Name of School Food Authority:</b> <b>SCVSFSA (School Day Café)</b>	<b>2. Name of School:</b>	<b>3. School Phone Number:</b>									
<b>4. Name of Child or Participant:</b>		<b>5. Date of Birth:</b>									
<b>6. Name of Parent or Guardian:</b>		<b>7. Phone Number:</b>									
<b>8. Select the Option that Best Describes Participant's Physical or Mental Impairment Affected:</b> <input type="checkbox"/> Participant has a disability or medical condition that requires a special meal and/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. <input type="checkbox"/> Participant does not have a disability, but is requesting a special meal or accommodation due to a food intolerance or other medical reason. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. <p style="text-align: center;"><b>A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.</b></p>											
<b>9. The participant's disability or medical condition requiring a special meal or accommodation:</b>											
<b>10. If participant has a disability, provide a brief description of their major life activity affected by the disability:</b>											
<b>11. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:</b>											
<b>12. Indicate Food Texture for Above Child or Participant:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed											
<b>13. Foods to be Omitted and Appropriate Substitutions:</b> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 50%; text-align: center; border: none;">Foods To Be Omitted</th> <th style="width: 50%; text-align: center; border: none;">Suggested Substitutions</th> </tr> </thead> <tbody> <tr> <td style="border: none; height: 20px;">_____</td> <td style="border: none; height: 20px;">_____</td> </tr> <tr> <td style="border: none; height: 20px;">_____</td> <td style="border: none; height: 20px;">_____</td> </tr> <tr> <td style="border: none; height: 20px;">_____</td> <td style="border: none; height: 20px;">_____</td> </tr> </tbody> </table>				Foods To Be Omitted	Suggested Substitutions	_____	_____	_____	_____	_____	_____
Foods To Be Omitted	Suggested Substitutions										
_____	_____										
_____	_____										
_____	_____										
<b>14. Adaptive Equipment to be Used:</b>											
<b>15. Signature of State Licensed Healthcare Professional*:</b>	<b>16. Printed Name:</b>	<b>17. Phone Number:</b>	<b>18. Date:</b>								

**\*For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or nurse practitioner.**

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

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](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.

## INSTRUCTIONS

1. **School or 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.
3. **Site Phone Number:** Print the phone number of site where meal will be served.
4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.
5. **Age of Child or Participant:** Print the age of the child or participant. For infants, please use date of birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.
7. **Phone Number:** Print the phone number of parent or guardian.
8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.
9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.
10. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".
11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).  
**Suggested Substitutions:** List specific foods to include in the diet (e.g., calcium-fortified juice).
12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
14. **Printed Name:** Print name of state licensed healthcare professional.
15. **Phone Number:** Phone number of state licensed healthcare professional.
16. **Date:** Date state licensed healthcare professional signed form.

### **Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:**

**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; 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.

**Major bodily functions** have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

**"Has a record of such an impairment"** means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.