# MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Return Completed Form to the School Front Office

| 1. Name of School Food Authority: **SCVSFSA (School Day Café)** | 2. Name of School: | 3. School Phone Number: |
|---|---|---|
| 4. Name of Child or Participant: | | 5. Date of Birth: |
| 6. Name of Parent or Guardian: | | 7. Phone Number: |

**8. Select the Option that Best Describes Participant's Physical or Mental Impairment Affected:**

☐ 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.

☐ 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.

**A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.**

**9. The participant's disability or medical condition requiring a special meal or accommodation:**

**10. If participant has a disability, provide a brief description of their major life activity affected by the disability:**

**11. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:**

**12. Indicate Food Texture for Above Child or Participant:**

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

**13. Foods to be Omitted and Appropriate Substitutions:**

| Foods To Be Omitted | Suggested Substitutions |
|---|---|
| | |
| | |
| | |

**14. Adaptive Equipment to be Used:**

| 15. Signature of State Licensed Healthcare Professional*: | 16. Printed Name: | 17. Phone Number: | 18. Date: |
|---|---|---|---|
| | | | |

***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.**

## 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.