MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1-23-18

1. District	2. School	3. School Telephone Number	
Westminster SD			
4. Name of Student	**5. Student ID #:**	**6. Date of Birth**	**7. Grade:**
8. Name of Parent or Guardian	**9. Telephone Number**	**10. Meals Needed:** ☐ Breakfast ☐ Lunch ☐ Supper	

11. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal 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. (**A licensed physician, physician's assistant or nurse practitioner must sign this form AND provide a list of appropriate meal substitutions**)

☐ Participant does not have a disability but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. 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, or nurse practitioner must sign this form)**

12. Disability or medical condition requiring a special meal or accommodation:

13. Provide a brief description of the participants major life activity affected by the disability or medical condition:

14. Are texture modifications required:	**15. Diet Prescription or accommodation required:**
☐ Soft ☐ Chopped ☐ Ground ☐ Pureed ☐ N/A	
16. Is the condition life threatening: ☐ Yes ☐ No	**17. Epi-Pen Prescribed:** ☐ Yes ☐ No

18. Attach a copy of special diet OR check the food allergies/intolerances below:

OMIT:	SUBSTITUTE:
☐Fluid Cow's milk ☐Food containing milk as an ingredient	☐ Soy Milk ☐ Lactose Free Milk
☐Cheese	☐Beef, ☐Poultry ☐ Sun butter
☐Whole Eggs alone ☐ Foods containing eggs as an ingredient	☐Beef, ☐Poultry, ☐Fish, ☐Beans, ☐ Sun butter ☐ Cheese, ☐Yogurt, ☐Egg-Free Breads
☐Wheat ☐Foods containing wheat as an ingredient ☐ Brown rice	☐Gluten free bread ☐Gluten free pasta ☐white rice
☐Peanuts, ☐Tree Nuts, (Walnuts, Cashews),	☐ Sun butter
☐Soy Beans, ☐Soy Bean oil ☐All soy as an ingredient	☐Soy-Free foods
☐Shellfish, ☐All Fish	☐Beef, ☐Poultry, ☐ Beans ☐Cheese ☐Yogurt
☐**Other**_____	Please Specify:

19. Signature of Preparer*	**20. Printed Name**	**21. Telephone Number**	**22. Date**
23. Signature of Medical Authority*	**24. Printed Name**	**25. Telephone Number**	**26. Date**

*** Physician, physician's assistant, or nurse practitioner must sign this form.**

Please allow up to 14 business days for processing of this form by Nutrition Services. You will be contacted by Nutrition Services & notified in writing with a determination and/or with the details of your student's meal accommodation(s).

District Use ONLY: (Initial below to confirm receipt)

Nutrition Manager/Specialist _____ School Nurse _____ Cafeteria Supervisor _____

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INSTRUCTIONS

1. **Westminster School District is printed in box 1.**
2. **School:** Print the name of the site where meals will be served (e.g., school site, child care 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. **Student Identification Number**: Print student's ID number.
6. **Age of Participant:** Print the age or date of birth of the participant. For infants, please use Date of Birth.
7. **Grade:** Print student's grade level for current school year.
8. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
9. **Telephone Number:** Print the telephone number of parent or guardian.
10. **Meals Needed:** Please check (✓) the meals that the student will eat at school on a daily basis.
11. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
12. **Disability or Medical Condition requiring a special meal or accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
13. **Brief Description of participants major life activity affected by the disability or medical condition:** Describe the major life activity such as caring for oneself, performing tasks, seeing, hearing, eating, sleeping, speaking, thinking, walking, thinking, etc. or the medical condition that occurs such as a rash on the body, shortness of breath, etc. when consuming this food
14. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, please check "N/A".
15. **Diet Prescription or accommodation required:** Describe the specific type of food or type of foods that the participant needs to consume. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods." or, "participant cannot consume any foods containing eggs"
16. **Is the condition life threatening:** Check (✓) yes or no.
17. **Is Epi-Pen prescribed:** Check (✓) yes or no.
18. A. **Foods to Be Omitted:** List or check (✓) specific foods that must be omitted.
    B. **Suggested Substitutions:** List or check (✓) specific foods to include in the diet.
19. **Signature of Preparer:** Signature of person completing form.
20. **Printed Name:** Print name of person completing form.
21. **Telephone Number:** Telephone number of person completing form.
22. **Date:** Date preparer signed form.
23. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
24. **Printed Name:** Print name of medical authority.
25. **Telephone Number:** Telephone number of medical authority.
26. **Date:** Date medical authority signed form.

DEFINITIONS*:
"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, 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, 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.

"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.

(*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)