

## MEDICAL STATEMENT TO REQUEST 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											
<p>8. Check One:</p> <p><input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> a special meal or accommodation. (Refer to instructions 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. <b>A licensed physician, a nurse practitioner (APN) or physician's assistant (PA) must sign this form.</b></p> <p><input type="checkbox"/> 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. <b>A licensed physician, registered dietitian, registered nurse, physician's assistant, or nurse practitioner must sign this form.</b></p> <p><input type="checkbox"/> Participant does not have a disability, but is requesting a special accommodation for a <b>fluid milk substitute</b> 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. <b>A licensed physician, registered dietitian, registered nurse, physician's assistant, nurse practitioner or parent or guardian may sign this form.</b></p>													
9. Disability or medical condition requiring a special meal or accommodation:													
10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:													
11. Diet prescription and/or accommodation: <i>(please describe in detail to ensure proper implementation-use extra pages as needed)</i>													
<p>12. Foods to be omitted and substitutions: <i>(please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed)</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center; border: none;"><b>A. Foods To Be Omitted</b></td> <td style="width: 50%; text-align: center; border: none;"><b>B. Suggested Substitutions</b></td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>				<b>A. Foods To Be Omitted</b>	<b>B. Suggested Substitutions</b>	_____	_____	_____	_____	_____	_____	_____	_____
<b>A. Foods To Be Omitted</b>	<b>B. Suggested Substitutions</b>												
_____	_____												
_____	_____												
_____	_____												
_____	_____												
<p>13. Indicate texture:</p> <p><input type="checkbox"/> Regular      <input type="checkbox"/> Chopped      <input type="checkbox"/> Ground      <input type="checkbox"/> Pureed</p>													
14. Adaptive Equipment:													
15. Signature of Preparer*	16. Printed Name	17. Telephone Number	18. Date										
19. Signature of Medical Authority*	20. Printed Name	21. Telephone Number	22. Date										

\* Physician's signature, APN or PA is required for participants with a disability. For participants without a disability, a licensed physician, registered dietitian, registered nurse, physician's assistant or nurse practitioner must sign the form. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.

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

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov). Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

## REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS INSTRUCTIONS

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 requesting 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. **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.)
10. **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 affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **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."
12. **A. Foods to Be Omitted:** List specific foods that must be omitted. For example, "exclude fluid milk."  
**B. Suggested Substitutions:** List specific foods to include in the diet. For example, "approved soy milk."
13. **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".
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a Sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **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 ADA, which expanded the definition of disability, can be found at:  
<http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf>