Medical Statement for Meal Modifications in School Nutrition Programs

This form applies to requests for meal modifications for children participating in the U.S. Department of Agriculture's (USDA) school nutrition programs. School nutrition programs include the National School Lunch Program (NSLP), School Breakfast Program (SBP), Afterschool Snack Program (ASP), Seamless Summer Option (SSO) of the NSLP, Special Milk Program (SMP), and Fresh Fruit and Vegetable Program (FFVP). Schools and institutions are required to make reasonable meal modifications for children whose physical or mental impairment restricts their diet. See *Instructions* page for additional guidance.

Please Note: For submitted medical statements, the USDA requires the parent/guardian includes: 1) information about the child's physical or mental impairment that is sufficient to allow the school food authority (SFA) to understand how the physical or mental impairment restricts the child's diet; 2) detailed steps or an explanation of what must be done to accommodate the child's disability; and 3) if appropriate, the food or foods to be omitted and recommended alternatives.

Section A – Completed by parent or guardian

1. Name of child:_____ 2. Birth date: _____
3. Name of parent or guardian: _____
4. Phone number (with area code): _____ 5. E-mail address: _____
6. Address:_____ City: _____ State: _____ Zip: _____
7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____
printed name of child's recognized medical authority

to release such protected health information of my child as is necessary for the specific purpose of special diet information to _____ and I consent to allow the recognized medical authority to freely
printed name of school district

exchange the information listed on this form and in my child's records with the school district as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that I may rescind permission to release this information at any time, except when the information has already been released.

8. Signature of parent or guardian:_____ 9. Date: _____

Section B – Completed by child's recognized medical authority

This section must be completed by the child's physician, physician assistant, doctor of osteopathy, or advanced practice registered nurse (APRN). APRNs include nurse practitioners, clinical nurse specialists, and certified nurse anesthetists who are licensed as APRNs.

10. **Physical or mental impairment:** Does the child have a physical or mental impairment that restricts the child's diet?

☐ **No** ☐ **Yes:** Describe in detail how the child's physical or mental impairment restricts the child's diet.

11. **Diet plan:** Explain the diet/meal modification for the child. Attach a specific diet/meal plan, if needed.

12. **Food omissions and substitutions:** List foods to be omitted/substituted from the child's diet/meal plan.

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Section B – Completed by child's recognized medical authority, continued

13. **Food texture:** List foods that require a change in texture. Indicate "all" if all foods should be prepared in this manner.

☐ Cut up or chopped into bite-size pieces: _____

☐ Finely ground: _____

☐ Pureed: _____

14. **Special Feeding Equipment:** List any special equipment or specialty utensils needed.

15. **Additional information:** Indicate any other information about the child's eating or feeding patterns that will assist in providing the requested meal modification

16. Printed name of recognized medical authority: _____

17. Phone number (with area code): _____

18. Signature of recognized medical authority: _____

19. Date: _____

20. Office stamp:

As policies indicate, provide information/copy to:

☐ **Cafeteria/FSMC** **Date:**

☐ **School nurse/Clinic** **Date:**

☐ **504 Committee** **Date:**

☐ **Filed with student records** **Date:**

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, 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:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
(2) fax: (833) 256-1665 or (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

INSTRUCTIONS

"A Person with a disability" is defined as any person who has a physical or mental impairment that 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 intellectual disability, 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.

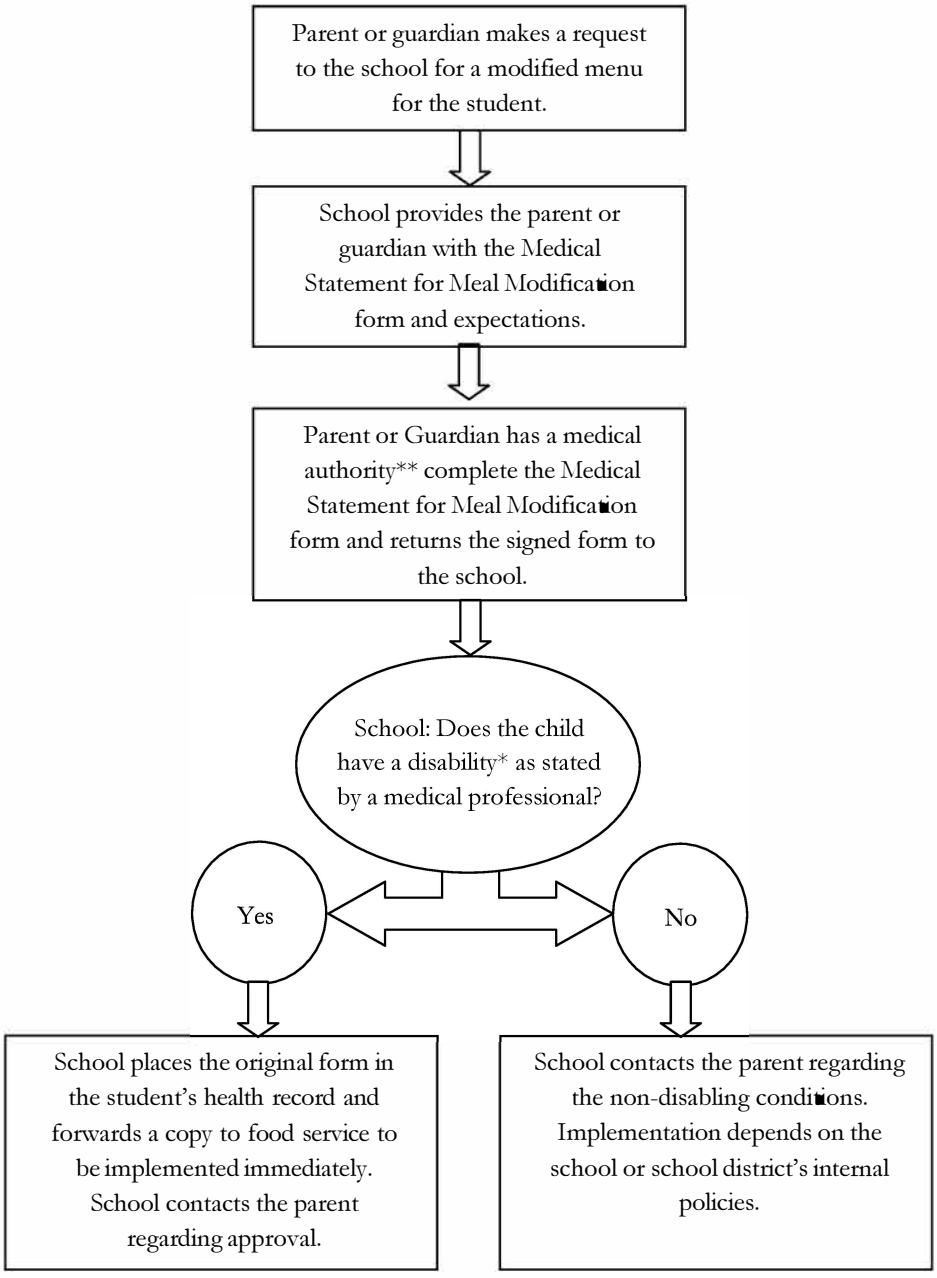
"Has a record of such an impairment" is defined as having a history of or has been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(CITATIONS FROM SECTION 504 OF THE REHABILITATION ACT OF 1973 AND AMERICANS WITH DISABILITIES ACT OF 1990)

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS INSTRUCTIONS

1. **Child Name**: Print the name of the student that is with requesting a meal modification.
2. **Date of Birth**: Print the date of birth of the student in 'month/day/year' format.
3. **Parent or Guardian Name:** Print the name of the person requesting the student's medical statement.
4. **Telephone Number:** Print the primary telephone number of the parent or guardian.
5. **E-mail Address:** List an email address that is current and checked regularly.
6. **Address**: Provide a home address where the student resides most of the time.
7. **Name of Child's Recognized Medical Authority:** Name of healthcare provider signing this form
   Name of School District:
8. **Parent or Guardian Signature: Signature of the person requesting the student's medical statement.**
9. **Date: Print the date the parent or guardian signed the document.**
10. **Check One: Check (✓) a box to indicate whether the student has a disability or does not have a disability.**
    If the Student has a disability, provide a description of the student's Major Life Activity affected by the disability. Describe how the physical or medical condition affects the student (e.g., allergy to peanuts causes a life-threatening reaction or diabetes and needs timed meals with insulin).
11. **Diet Plan and/or Accommodation:** Describe a *specific* diet (or accommodation (e.g., soft foods) that has been prescribed by a physician or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods).
12. **Foods to be Omitted and Substitutions:** List specific foods that must be omitted (e.g., exclude fluid milk). If specific foods do not need to be omitted, skip this question. **Suggested Substitutions**: List specific foods to include in the diet (e.g., calcium-fortified milk).
13. **Food Texture:** Check (✓) a box to indicate the type of texture accommodation of foods that is needed. If the student does not need any texture modification, skip this question.
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., a sippy cup, a large handled spoon, suction plate).
15. **Additional Information:** List any other information related to meals or eating that might be helpful.
16. **Printed Name of Medical Authority:** Print the name of the medical authority.
17. **Telephone Number:** Print the telephone number with area code, of the medical authority.
18. **Signature of Medical Authority:** Signature of the medical authority requesting a special meal or accommodation.
19. **Date:** Print the date the medical authority signed the form.
20. **Office Stamp of Medical Authority:** Must be completed by medical authority staff member and should include name of medical practice, address and phone number

SUGGESTED FLOW FOR HANDLING MEAL MODIFICATION REQUESTS



* Disability: a physical or mental impairment that substantially limits one or more major life activities including, but not limited to, seeing, hearing, walking, speaking, learning, reading, eating, breathing etc.

** Medical Authority: a state licensed health care professional authorized to write medical prescriptions must sign this form. Includes: Licensed Physicians (MD, DO), Advanced Registered Nurse Practitioners (ARNP), and Physician's Assistants (PA).