



Child Nutrition Programs Medical Statement to Request Special Meals and/or Accommodations



A recognized Medical Authority must fill out a Medical Statement to Request Special Meals and/or Accommodations form and return it to the school, child or adult care facility/provider. Agencies have an obligation to provide alternate foods to those participants who meet any of the following definitions.

Definitions:

“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 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, specific learning disabilities.

“Major life activities” are defined as “functions such as 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, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions.”

“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.

“Recognized Medical Authority” means state recognized medical professional with prescriptive authority such as, licensed physician, physician’s assistant, or nurse practitioner.

The medical statement shall identify:

- The participant’s disability or medical condition with an explanation of why the disability restricts the participant’s diet;
- The major life activity affected by the disability;
- The specific diet or accommodation that has been prescribed by the medical authority. For example: “All foods must be in liquid or pureed form. Participant cannot consume any solid foods.”
- The type of texture of food that is required,
- The specific foods that must be omitted and suggested substitutions
- The specific equipment required to assist the participant with dining. Examples might include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.



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Please fax form to
School or Child Care Provider
Fax Number: 907-826-3322

***Form must be signed by state recognized medical professional with prescriptive authority such as, licensed physician, physician's assistant, or nurse practitioner. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.**

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 of Guardian		7. Telephone Number	
8. Description of Child's Physical or Mental Impairment Affected:			
9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation: <i>(please describe in detail to ensure proper implementation-use extra pages as needed)</i>			
10. 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>			
A. Food To Be Omitted:		B. Suggested Substitutions:	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
11. Indicate texture: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed			
12. Adaptive Equipment to be Used:			
13. Signature of Preparer*		14. Printed Name	15. Telephone Number
17. Signature of Medical Authority*		18. Printed Name	19. Telephone Number
			20. Date

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. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child's diet.
9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribe by the state healthcare professional.
10. **A. Foods to Be Omitted:** List specific foods that must be omitted. (e.g., exclude fluid milk.)
B. Suggested Substitutions: List specific foods to include in the diet. (e.g., calcium fortified juice.)
11. **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".
12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the participant with dining. (e.g., a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
13. **Signature of Preparer:** Signature of person completing form.
14. **Printed Name:** Print name of person completing form.
15. **Telephone Number:** Telephone number of person completing form.
16. **Date:** Date preparer signed form.
17. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
18. **Printed Name:** Print name of medical authority.
19. **Telephone Number:** Telephone number of medical authority.
20. **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 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 ADAAA, which expanded the definition of disability, can be found at: <http://www.law.georgetown.edu/archiveada/documents/comparisonofADAandADAAA.pdf>

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

REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form, \(AD-3027\)](#) online and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;*

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

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