MEDICAL STATEMENT TO REQUEST CHILD NUTRITION PROGRAMS 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

8. Check One:

☐ Participant has a disability, which may include a food allergy, and requires a special meal or accommodation. Schools and agencies must make reasonable modifications to the meal to accommodate a disability which restricts a participant's diet. Modifications during and for food service may be required. Schools and agencies participating in federal nutrition programs must comply with requests for special meals. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** 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. **A licensed physician, physician's assistant, nurse practitioner, parent, or guardian may sign this form.**

9. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

10. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation-use extra pages as needed*)

11. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

12. Schools and agencies are not required to provide the exact substitution or other modification requested. However, must offer a reasonable modification that effectively accommodates the participant's disability and provides equal opportunity to participate in or benefit from the federal nutrition programs.

Foods to be omitted and available/acceptable substitutions: (*please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Available/Acceptable Substitutions

13. Modifications to meal service:

14. Signature of Preparer*	15. Printed Name	16. Telephone Number	17. Date

18. Signature of Medical Authority**	19. Printed Name	20. Telephone Number	21. Date

***Parent/legal guardian signature is acceptable for fluid milk substitution for a child with dietary needs other than a disability.**
****Medical Authority's signature is required for participants with a disability.**
The information on this form should be updated to reflect any changes to the current medical and/or nutritional needs of the participant, and updated annually.