MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Child or Adult Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Telephone Number

8. Check One:

☐ Participant has a disability or a medical condition that **requires** a special meal and/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.

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to a food intolerance or other medical reason. 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 assistant, or nurse practitioner must complete and sign this form.

9. The participant's disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of his/her major life activity affected by the disability:

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

12. Indicate food texture for above participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. Foods to be omitted and 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. Suggested Substitutions

14. Adaptive equipment to be used:

15. Signature of Recognized Medical Authority*	16. Printed Name	17. Telephone Number	18. Date

***For this purpose, a recognized medical authority in California is a licensed physician, physician assistant, or nurse practitioner.**

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

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, 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 (e.g., 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 the recognized medical authority.
12. **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".
13. 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).
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
15. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
16. **Printed Name:** Print name of medical authority.
17. **Telephone Number:** Telephone number of medical authority.
18. **Date:** Date medical authority signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

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; 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.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

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

School _____

School Phone # _____

School Fax # _____

Modified Physical Education or Daily Recess Restrictions

This form should be completed so that a student with a medical disability or injury may participate in physical education (PE), as required by California Education Code, or may participate in daily student recess. (California Education Codes 51206, 51210, 51211, 51220, 51223)

Student Name: _____ **Date of Birth:** _____ **School Name:** _____

Diagnosis/Surgery: _____ *(Optional)*

Choose an appropriate PE program, or activity level:

☐ Regular physical education program, or activity level, (No modification required).

☐ Exemption* from physical education (student cannot safely participate in any PE). *Note: California requires 2 years of PE for High School graduation.*

☐ May participate in physical education, or recess, with the following restrictions:
(Please give a brief description and check appropriate boxes. Include any limits set on activities for safety or medical reasons.)

Complete one of the following:

A. MAY PARTICIPATE IN THE FOLLOWING SPORTS:

☐Baseball ☐Basketball ☐Football ☐Golf ☐Running ☐Soccer ☐Softball ☐Swimming ☐Tennis ☐Volleyball ☐_____

B. ACTIVITY RECOMMENDATIONS (Please check where appropriate and add comments if applicable)

TYPE OF ACTIVITY	OMIT	MILD	MODERATE	UNLIMITED	COMMENTS
Aerobic					
Bending					
Catching					
Climbing					
Hanging					
Jumping					
Kicking					
Lifting					
Pulling					
Pushing					
Running					
Squatting					
Stretching					
Throwing					
Twisting					
Walking					

Above restrictions / limitations are for dates: ☐ _____ to _____ ***OR*** ☐ One Semester ***OR*** ☐ Until the end of the school year

Physician Signature: _____ ***Date:*** _____

Physician Name: _____

Address: _____ **Phone:** _____

City: _____ **Zip:** _____

I give permission to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ ***Date:*** _____ **Phone:** _____

This form must be <u>renewed</u> each school year or with any change or modification in physical education or activity restrictions.

* California Education Code establishes requirements for physical education at all levels. In addition, California Education Code provides for Temporary or Permanent Exemption from Physical Education for medical reasons. (California Education Codes 51241, 51246)