SHAWNEE MISSION SCHOOL DISTRICT

Medical Statement to Request Meal Modification

Letter to Parent/Guardian Explaining Requirements

2022-23

Dear Parent/Guardian:

Your student's school will make meal modifications prescribed by a licensed medical authority that is authorized by Kansas state law to write medical prescriptions (MD, DO, PA, or APRN) to accommodate a disability. A *Medical Statement to Request School Meal Modification* is attached to this letter and can be used to request a meal modification.

To ensure the requested meal modifications can be made, return the completed medical statement to your school nurse. It will take approximately a week from the time the request is received until it can be implemented with Food Services.

IMPORTANT: For a student who does not have a disability, the meal must meet the reimbursable meal pattern. No substitutions will be made for vegan diet, religious, ethical or cultural reasons.

If you have questions or need assistance, please contact your school nurse or the Food Service office.

Sincerely,

SMSD Food Services

Medical Statement to Request Meal Modification

Modifications to Accommodate a Disability: Meal modifications prescribed by a medical authority will be made to accommodate a student's disability.

Definition of Disability: Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability 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. "Major life activities" are broadly defined and 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 life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

This form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced practice registered nurse (APRN) authorized by their responsible licensed physician.

Part A. Participant, Parent/Guardian, School Contact Information – To be completed by a parent/guardian or facility contact person.

Participant's Name:	Date of Birth:	School:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
School Contact's Name:	School Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Description of the physical or mental impairment related to the prescribed diet order and major life activity affected.
   Example: Allergy to peanuts affects ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Special Feeding Equipment _____
(e.g. large handled spoon, sippy cup, etc.)

3. Medical Authority's Information:

Signature: Title:

Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for facility personnel responsible for implementing the prescribed diet order to discuss the special dietary accommodations with any appropriate staff and to follow the prescribed diet order for meals. I also give permission for the medical authority to further clarify the prescribed diet order on this form if requested to do so by facility personnel.

Parent/Guardian's Signature: Date: