Medical Statement for Student Requiring Special Meals Due to Food Allergy or Intolerance

Student Name: _____ District: _____

Birth Date: _____ School: _____

Parent Name: _____ School Contact: _____

Address: _____ School Address: _____

Phone: _____ School Phone: _____

To be completed by a recognized medical authority (i.e. a licensed physician, physician's assistant or nurse practitioner)

The school is not required to provide substitutions for an allergy or food intolerance, and is permitted to do so **ONLY** when omitted foods and appropriate substitutions are specified by a medical authority. If diet modifications are implemented by the school, they will continue until a medical authority specifies that they should be changed or stopped. Parents/guardians are asked to annually request updated instructions for diet modifications from a medical authority.

☐ Student has a disability affecting the diet that meets the definition of "disability" as described on the reverse side of this form. If yes, complete Medical Statement for Student Requiring Special Meals Due to Disability.

Diet Prescription (check all that apply):

☐ Milk/Dairy Products Allergy – No fluid cow's milk or any other food product made with cow's milk such as cheese, yogurt, dried milk powder, etc. * * * If student has intolerance to milk and/or milk products, then please complete Form 21-G, Request to Omit Fluid Cow's Milk.

☐ Other (describe):_____

☐ Food allergies – Please check appropriate box(es): ☐ ingestion ☐ contact ☐ inhalation

List the specific food(s) to be omitted and food(s) that may be substituted. If more space is needed for omitted foods or substitutions, please continue on reverse side of form. Specific foods to be omitted and specific foods to be substituted must be listed below or this statement will be returned to the physician/medical authority for clarification.

Meal Modification Start Date:_____ End Date: _____

Omit Foods Listed Below:	**Substitute Foods Listed Below:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Continued on reverse side

Medical Statement for Student Requiring Special Meals Due to Food Allergies or Intolerances (continued)

Comments:

Physician/Medical Authority's Certification:

I certify that the student named on this form needs the prescribed food and/or beverage omission(s) and substitution(s) due to his/her food allergy (ies) and/or food intolerance(s).

_____
Medical Authority's Printed Name

_____	_____	_____
Medical Authority's Signature	Phone Number	Date
_____	_____	_____
Preparer or Other Contact's Signature	Phone Number	Date

Parent/Guardian's Consent

I hereby give permission for the school staff to make the prescribed food and/or beverage omission(s) and substitution(s) in my child's school meals. Furthermore, should the school staff require additional information to clarify how to carry out the diet prescription or food omissions and substitutions; I hereby give permission for my child's physician/medical authority to provide any additional information necessary to clarify the diet prescription written on this form.

_____	_____	_____
Parent/Guardian's Signature	Phone Number	Date

Definition of Disability:

Federal regulations governing the Child Nutrition Programs provide that schools must make substitutions in breakfasts, lunches and afterschool snacks for students who are considered to have a disability and whose disability restricts their diet.

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a "person with a disability" means "any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment." The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as:

- Cancer
- Cerebral Palsy
- Drug addiction and alcoholism
- Emotional illness
- Epilepsy
- Food anaphylaxis (severe food allergy)
- Heart disease
- HIV
- Mental retardation
- Metabolic diseases, such as diabetes or phenylketonuria (PKU)
- Multiple Sclerosis
- Muscular Dystrophy
- Orthopedic, visual, speech and hearing impairments
- Specific learning disabilities
- Tuberculosis

The Individuals with Disabilities Education Act (IDEA) includes the following conditions:

- Autism
- Deaf-blindness
- Deafness or other hearing impairments
- Emotional disturbance
- Mental retardation
- Multiple disabilities
- Orthopedic impairments
- Other health impairments due to chronic or acute health problems, such as asthma, diabetes, nephritis, sickle cell anemia, a heart condition, epilepsy, rheumatic fever, hemophilia, leukemia, lead poisoning, or tuberculosis
- Specific learning disabilities
- Traumatic brain injury
- Visual impairment, including blindness which adversely affects a child's educational performance

Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

This institution is an equal opportunity provider.

Medical Statement for Student Requiring Special Meals Due to Disability

Student Name: _____ District: _____

Birth Date: _____ School: _____

Parent Name: _____ School Contact: _____

Address: _____ School Address: _____

Phone: _____ School Phone: _____

To be Completed by a Licensed Physician:
The school will make diet modifications for a disability **ONLY** when omitted foods and appropriate substitutions are prescribed by a licensed physician. If diet modifications are implemented by the school, they will continue until a licensed physician specifies that they should be changed or stopped. Parents/guardians are encouraged to annually request updated instructions for diet modifications from a licensed physician.

Disability:
Identify the disability (see definition on back of form) that causes the student to require diet modifications.

Describe the major life activities, affected by the disability, that require diet modifications.

Diet Prescription: Check all that apply.

- ☐ Diabetic meal plan. Please specify_____
  _____
- ☐ Gluten-free meal plan. Please omit all products containing wheat, rye, barley and oats.
- ☐ Modified texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed
  ☐ Other (describe): _____
- ☐ Modified thickness of liquids: ☐ Regular ☐ Nectar ☐ Honey ☐ Pudding
- ☐ Other (describe):_____

List the specific food(s) to be omitted and food(s) that may be substituted. If more space is needed for omitted foods or substitutions, please attach an additional page.

Meal Modification Start Date:_____ End Date: _____

Omit Foods Listed Below:	**Substitute Foods Listed Below:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Special Feeding Equipment: _____

Continued on reverse side.

Comments:

Physician's Certification:
I certify that the student named on this form needs the prescribed food and/or beverage omission(s) and substitution(s) due to his/her disability/disabilities.

_____
Licensed Physician's Printed Name

_____	_____	_____
Licensed Physician's Signature	Phone Number	Date
_____	_____	_____
Preparer or Other Contact's Signature	Phone Number	Date

Parent/Guardian's Consent:
I hereby give permission for the school staff to make the prescribed food and/or beverage omission(s) and substitution(s) in my child's school meals. Furthermore, should the school staff require additional information to clarify how to carry out the diet prescription or food omissions and substitutions; I hereby give permission for my child's physician to provide any additional information necessary to clarify the diet prescription written on this form.

_____	_____
Parent/Guardian Signature	Date

Definition of Disability:
Federal regulations governing the Child Nutrition Programs provide that schools must make substitutions in breakfasts, lunches and afterschool snacks for students who are considered to have a disability and whose disability restricts their diet.

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a "person with a disability" means "any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment." The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as:

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- Drug addiction and alcoholism
- Emotional illness
- Epilepsy
- Food anaphylaxis (severe food allergy)
- Heart disease
- HIV
- Mental retardation
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- Specific learning disabilities
- Traumatic brain injury
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Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

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Request to Omit Fluid Cow's Milk

Student Name: _____ District: _____

Birth Date: _____ School: _____

Parent Name: _____ School Contact: _____

Address: _____ School Address: _____

Phone: _____ School Phone: _____

To be completed by a recognized medical authority such as a physician, physician's assistant, nurse practitioner OR by a parent/guardian.

The school is not required to provide substitutions for a milk allergy, lactose intolerance, or for any other non-medical reason, and is permitted to do so **only** when omitted foods and appropriate substitutions are specified by a recognized medical authority or parent/guardian. If diet modifications are implemented by the school, they will continue until either a recognized medical authority or a parent/guardian specifies that they should be changed or stopped. Parents/guardians are encouraged to annually provide updated instructions for diet modifications from a recognized medical authority or a parent/guardian.

Dietary Accommodations: Select one.

☐ **Lactose Intolerance – Please offer student:**
- ☐ Lactose-free milk
- ☐ Milk substitute approved by USDA

OR

☐ **Milk allergy – Instead of fluid cow's milk, please offer student:**
- ☐ Milk substitute approved by USDA (Use Form 21-E to list specific omissions and substitutions)

OR

☐ **Religious, ethical or cultural reasons – Instead of fluid cow's milk, please offer student:**
- ☐ Milk substitute approved by USDA

Certification:

I certify that the student named on this form needs the prescribed fluid cow's milk omission and substitution(s) due to his/her milk allergy or lactose intolerance(s).

_____ _____ _____
Medical Authority's Signature | Phone Number | Date

OR

I hereby give permission for the school staff to omit fluid cow's milk and make the above identified substitution(s) in my child's school meals.

_____ _____ _____
Parent/Guardian's Signature | Phone Number | Date

This institution is an equal opportunity provider.

Discontinuation of Diet Instructions for Allergies, Intolerances or Disabilities

Name of Medical Authority: _____

Name of Student: _____

School: _____

I certify that the student named above is no longer in need of special school meals effective on the following date: _____.

_____ _____
Signature of Recognized Medical Authority Date

_____ _____
Street Address Phone Number

_____
City, State, Zip

_____ _____
Parent/Guardian Signature Date

Parent/Guardian

I give _____ school's personnel permission to contact the medical
(Name of School)
authority named above in order to clarify dietary needs for my child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Street Address, City, State, Zip Phone Number

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "The U.S. Department of Agriculture (USDA) prohibits Discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish).

Discontinuation of Fluid Cow's Milk Omission

Name of Student: _____

School: _____

I certify that the student named above no longer needs the omission of fluid cow's milk from school meals effective on the following date: _____.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Street Address Phone Number

_____
City, State, Zip

OR

Printed Name of Medical Authority: _____

_____ _____
Recognized Medical Authority's Signature Date

_____ _____
Street Address Phone Number

_____
City, State, Zip

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If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

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