

May 24, 2024

Dear Parent/guardian:

USD 232 Student Nutrition is prepared to assist families and students by providing reasonable meal modifications prescribed by an authorized medical authority to accommodate a child's disability.

In order to best assist our families with these accommodations, documentation of the student's disability must be provided. The preferred method is through completion of the *Medical Statement to Request School Meal Modification* form which is attached to this letter.

A medical authority's prescription may also be provided as long as the following information is included on official letterhead:

- prescribed diet order
- description of the child's physical or mental impairment related to the prescribed diet order
- major life activity affected
- explanation of what must be done to accommodate disability
- prescribed omission and/or substitution of foods (if applicable)
- signature of medical authority (may be digital)

Please note that all forms and prescriptions must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO), physician's assistant (PA) OR advanced registered nurse practitioner (ARNP) authorized by their responsible licensed physician.

To ensure requested meal modifications can be made on the first day of school, return the completed documentation by **August 1** of the upcoming school year to Jolyn Baldner in one of the following manners:

- Mail or drop off completed form at USD 232 District Offices, 35200 W 91<sup>st</sup> St, De soto, KS 66018; OR
- Email a scanned copy of the completed form to [jbaldner@usd232.org](mailto:jbaldner@usd232.org)

If you are submitting a request for meal modification at a time other than the beginning of the school year, please allow approximately 10 school days from the time the request is received until it can be implemented. In the time the form is received and before implementation, we will discuss ways to keep your child safe. If you have questions or need assistance, please call Jolyn Baldner at 913-667-6200.

Sincerely,



Jolyn Baldner, MS, RDN  
Director of Student Nutrition

# Medical Statement to Request Meal Modification

**Modifications to Accommodate a Disability:** Meal modifications prescribed by a medical authority must be made to accommodate a participant'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.**

<b>Part A. Participant, Parent/Guardian, Facility Contact Information – To be completed by a parent/guardian or facility contact person.</b>		
Participant's Name:	Date of Birth:	Facility:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
Facility Contact's Name:	Facility Contact's Phone:	
<b>Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.</b>		
1. Description of the physical or mental impairment related to the prescribed diet order and major life activity affected. <i>Example: Allergy to peanuts affects ability to breathe.</i>		
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:	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed
Modified Thickness of Liquids:	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Nectar <input type="checkbox"/> Honey <input type="checkbox"/> Spoon or Pudding Thick
Special Feeding Equipment:	<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Special Feeding Equipment _____ <small>(e.g. large handled spoon, sippy cup, etc.)</small>
3. Medical Authority's Information:		
Signature:	Title:	
Printed Name:	Phone:	Date:
<b>Part C. Parent/Guardian Permission – To be completed by a parent/guardian</b>		
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:	

This institution is an equal opportunity provider.