

## MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

<b>1. School Name</b> THOMPSON FALLS SCHOOL DISTRICT #2		<b>2. School Telephone Number</b> 406.827.3592							
<b>3. Student Name</b>		<b>4. Age or Date of Birth</b>							
<b>5. Parent or Guardian Name</b>		<b>6. Telephone Number</b>							
<b>7. Check One:</b> <input type="checkbox"/> The student has a disability or a medical condition and requires a special meal or accommodation (Refer to the definitions on page 2). Schools participating in the National School Lunch Program must comply with requests for special meals and any adaptive equipment. <u>A licensed physician must sign this form.</u>  <input type="checkbox"/> The student does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools participating in the National School Lunch Program are encouraged to accommodate reasonable requests. <u>A licensed physician, physician's assistant, or nurse practitioner must sign this form.</u>									
<b>8. Disability or medical condition requiring a special meal or accommodation:</b>									
<b>9. If the student has a disability, provide a brief description of the student's major life activity affected by the disability:</b>									
<b>10. Diet prescription and/or accommodation:</b> <i>Please describe in detail to ensure proper implementation – use extra pages if needed.</i>									
<b>11. Indicate texture modification request (if applicable):</b> <input type="checkbox"/> Ground <input type="checkbox"/> Soft <input type="checkbox"/> Pureed <input type="checkbox"/> Liquid									
<b>12. Foods to be omitted and substitutions (if applicable):</b> <i>Please list specific foods to be omitted and suggested substitutions – use extra pages if needed.</i> <table style="width: 100%; margin-top: 10px;"> <thead> <tr> <th style="width: 50%; text-align: center;">Foods to be Omitted</th> <th style="width: 50%; text-align: center;">Suggested Substitutions</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>				Foods to be Omitted	Suggested Substitutions	_____	_____	_____	_____
Foods to be Omitted	Suggested Substitutions								
_____	_____								
_____	_____								
<b>13. Adaptive Equipment:</b>									
<b>14. Parent of Guardian Signature</b>			<b>15. Date</b>						
<b>16. Preparer's Signature</b>	<b>17. Printed Name</b>		<b>18. Date</b>						
<b>19. Medical Authority's Signature*</b>	<b>20. Printed Name</b>	<b>21. Telephone Number</b>	<b>20. Date</b>						

\*A physician's signature is required for students with a disability. For students without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.

**INTERNAL USE ONLY:**

Date Received by School:	Date Placed in Student Health Record:	Date Copy Given to Food Service:
Recipients Signature:	Filer's Signature	Recipients Signature:

"In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

# MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

## INSTRUCTIONS

1. **School Name:** Print the name of the school that is providing the form to the parent or guardian.
2. **School Telephone Number:** Print the telephone number of the school.
3. **Student Name:** Print the name of the student to whom the information pertains.
4. **Age or Date of Birth:** Print the age of the student. For infants, please use date of birth.
5. **Parent or Guardian Name:** Print the name of the person requesting the student's medical statement.
6. **Telephone Number:** Print the telephone number of the parent or guardian.
7. **Check One:** Check (✓) a box to indicate whether the student has a disability or does not have a disability.
8. **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).
9. **If the Student has a Disability, Provide a Brief Description of the Student's Major Life Activity Affected by the Disability:** Describe how the physical or medical condition affects the student (e.g., allergy to peanuts causes a life-threatening reaction).
10. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods).
11. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the student does not need any modification, skip this question.
12. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk). If specific foods do not need to be omitted, skip this question.  
**Suggested Substitutions:** List specific foods to include in the diet (e.g., calcium fortified milk)
13. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., a sippy cup, a large handled spoon, blender)
14. **Parent or Guardian Signature:** Signature of person requesting the student's medical statement.
15. **Date:** Print the date the parent or guardian signed the document.
16. **Preparer's Signature:** Signature of person completing the form.
17. **Printed Name:** Print the name of the person completing the form.
18. **Date:** Print the date the preparer signed the form.
19. **Medical Authority's Signature:** Signature of the medical authority requesting a special meal or accommodation.
20. **Printed Name:** Print the name of the medical authority.
21. **Telephone Number:** Print the telephone number of the medical authority.
22. **Date:** Print the date the medical authority signed the form.

## DEFINITIONS\*

**"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, including 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.

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

(\*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)