MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

This form is for medical purposes only, not personal or religious preferences.

Please fill out completely and return to school cafeteria supervisor or email ChildNutrition@lbschools.net.

1. Name of Student:	2. Student ID #:	3. Date of Birth:	4. Grade Level:
5. School Name:	6. Meals Needed: ☐ Breakfast ☐ Lunch ☐ Supper/After School Program After School Program Name: _______________		
7. Name of Parent or Guardian:	8. Phone Number of Parent/Guardian:	9. Email of Parent/Guardian:	

10. Description of Child or Participant's Physical or Mental Impairment Requiring a Special Meal or Accommodations:

11. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

12. Does the Student Need Food Texture Modifications? (if Yes, SELECT ONLY ONE; if No, leave blank):

☐ **Chopped** ☐ **Ground** ☐ **Pureed**

13. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Restricted	**Suggested Substitutions**
☐ Fluid Cow's Milk ☐ Cheese ☐ Yogurt ☐ All Products with Traces of Dairy (Bread, Whey, etc.)	☐ Soy Milk
☐ Whole Eggs (Scrambled Eggs, Egg Patties, etc.) ☐ All Products with Traces of Egg (Waffles, Ranch, etc.)	
☐ Gluten/Wheat	
☐ Peanuts ☐ Tree Nuts	
☐ Soy Beans (Edamame, Tofu, Soy Milk, etc.) ☐ All Products with Traces of Soy	
☐ Seafood (Fish, Shellfish, etc.)	
☐ Sesame	
☐ Other (Please Specify):	Please Specify:

14. Is the Food Allergy Life Threatening? ☐ Yes ☐ No	15. Adaptive Equipment to be Used:		
16. Signature of State Licensed Healthcare Professional*:	17. Printed Name:	18. Phone Number:	19. Date:

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, nurse practitioner, or registered dietitian.**

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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.
To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027 (PDF), found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

1. mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW, Mail Stop 9410 Washington, D.C. 20250-9410;
2. fax: 202-690-7442; or
3. email: Program.Intake@usda.gov.
This institution is an equal opportunity provider

INSTRUCTIONS

1. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.
2. **Student ID #:** Print the child or participant's school identification number, if known.
3. **Date of Birth:** Print the date of birth of the child or participant.
4. **Grade Level:** Print the child or participant's grade level.
5. **School Name:** Print the name of the site where meals will be served.
6. **Meals Needed**: Indicate all the meals the child participates in at school. If child participates in an after-school program, print which program.
7. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.
8. **Phone Number of Parent/Guardian:** Print the phone number of parent or guardian.
9. **Email of Parent/Guardian:** Print the email address of parent or guardian.
10. **Description of Child or Participant's Physical or Mental Impairment Requiring a Special Meal or Accommodations:** Describe how the physical or mental impairment restricts the child or participant's diet.
11. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.
12. **Indicate Texture:** If the child or participant needs a modified food texture for medical reasons, select ONE option. All foods will be of selected texture. If the child or participant does not need modified food textures, skip to the next section.
13. **Foods to be Restricted:** Check or list specific foods that must be omitted (e.g., restrict fluid cow's milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., soy milk).
14. **Is the Condition Life Threatening?** : Check "Yes" if the food allergy is life threatening or requires and Epi-pen. If the allergy is not life threatening, check "No".
15. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
16. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
17. **Printed Name:** Print name of state licensed healthcare professional.
18. **Phone Number:** Phone number of state licensed healthcare professional.
19. **Date:** Date state licensed healthcare professional 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. **information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.**

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.