Bearcat Diner
District Lunch Program
2025-2026

320 W. 24th Street
Administration Building
Kearney, NE 68845

Meal accommodation request policy

This form is **not** intended for modification requests that are because of a Life threatening allergy. Requests made for these reasons must go through the **School Nurse.**

If a dietary request is to accommodate an intolerance or other medical condition that doesn't rise to the level of disability is made, reasonable attempts to honor the request will be made by Bearcat Diner. (State and Federal laws state that schools/agencies may, at their discretion, make substitutions for participants who have a special dietary need that doesn't meet the definition of a disability.)

You as the student's parent/guardian are important to this process. Fill out the attached form(s) and return it/them to Bearcat Diner with the proper signatures and supporting documentation from a health care provider.

If you have any questions please contact Bearcat Diner at (308)698-8160 and we will be happy to talk with you about your student.

Thank you for your involvement in your student's experience at Bearcat Diner.

Shelia Sanford
Food Service Director BCD
shesanford@kearneycats.com
(308)698-8160

MEDICAL STATEMENT FORM TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

This form is to be used to request meal modification(s) for participants in the National School Lunch Program, Child and Adult Care Food Program, and/or Summer Food Service Program
(See Attached Instructions for Completing this Form)

PART A: Parent/Guardian completes this section – please print.

1. Name of Participant:		2. Date of Birth:
3. Name of Parent/Guardian:		4. Telephone:
5. Address:	6. City:	7. State/Zip:
8. Email Address:		

9. **I give permission** for the school/agency personnel responsible for implementing my child's prescribed diet order to share information with employees in order to accommodate this food modification request at other school/agency activities involving food.

☐ Yes ☐ No

Parent/Guardian Signature: _____ Date:_____

10. **Modification Option #1. Milk Substitution Request Only** (If applicable, Parent/Guardian must check box and sign):

☐ Participant is requesting substitution for fluid cow's milk due to lactose intolerance, vegan diet, religious, cultural, or ethical reasons. This milk substitution request can be made by the parent/guardian signing this form.

Parent/Guardian Signature: _____

IMPORTANT: *For a student who does not have a recognized disability, the only fluid cow's milk substitutions allowed by USDA are (1) Lactose-free fluid cow's milk or a (2) Non-dairy beverage with a nutrient profile equivalent to fluid cow's milk as specified in federal regulations. Currently, the only beverages meeting these specifications are certain brands of soymilk (8th Continent, Kikkoman Pearl, and Pacific Brand Ultra).*

A physician/medical authority signature and completion of Parts B or C of this form is NOT required if this is the only requested substitution.

PART C: (Modification Option #3) Medical Statement *(For participants without a disability)*

Completion of this PART C Medical Statement is required when the requested modification is due to a food allergy/intolerance, or other medical condition that does not rise to the level of a disability. *Please note: The school/agency may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need.*

To be completed by a Licensed Physician (MD or DO), or other recognized medical authority for this purpose: Physician's Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor. A Licensed Medical Nutrition Therapist (LMNT) also may complete and sign Part C when acting under the consultation of a licensed physician. *Please note: LMNT's must list the referring physician in Section 26.*

21. **Diagnosis** *(Specify the food allergy/intolerance or medical condition and explain why it restricts the participant's diet.)*

22. **Specify any dietary restrictions or special diet instructions for meals:**

23. If applicable, list the foods to be omitted and substituted in the diet (attach additional sheets if needed):

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

24. Modified Texture:	☐ Not applicable	☐ Chopped	☐ Ground	☐ Pureed
25. Modified Thickness of Liquids:	☐ Not applicable	☐ Nectar	☐ Honey	☐ Pudding Thick

26. Signature of Physician/Other Medical Authority/LMNT: _____

27. Name of referring physician working with LMNT ***(if applicable):*** _____

28. Printed Name and Title: _____

29. Phone Number: _____

30. Date: _____

Participant's Name_____