



MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School	2. Site Name	3. Site Phone Number																
4. Name of Child		5. Age or Date of Birth																
6. Name of Parent or Guardian		7. Phone Number																
8. Description of Child's Physical or Mental Impairment Affected:																		
9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:																		
10. Indicate Food Texture for Above Child: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed																		
11. Adaptive Equipment to be Used:																		
12. Foods to be Omitted and Appropriate Substitutions: <table border="0" style="width: 100%;"><thead><tr><th style="text-align: center;">Foods To Be Omitted</th><th style="text-align: center;">Suggested Substitutions</th></tr></thead><tbody><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></tbody></table>			Foods To Be Omitted	Suggested Substitutions														
Foods To Be Omitted	Suggested Substitutions																	
13 and 14: Only complete if applicable to student	13. Milk/Dairy Allergy or Intolerance: This student is <u>NOT</u> able to eat/drink the following (check all that apply) ☐ Fluid Cow's Milk ☐ Lactose Free Cow's Milk ☐ Baked foods containing Milk/Dairy ☐ Yogurt ☐ Cheese ☐ Condiments containing Milk/Dairy products																	
	14. Egg Allergy or Intolerance: This student is <u>NOT</u> able to eat the following (check all that apply) ☐ Scrambled Egg/Egg Patty ☐ Condiments containing eggs (mayonnaise, salad dressing, etc) ☐ Baked good containing Egg ☐ Foods containing eggs as a a minor ingredient																	
15. Signature of Registered Dietitian (RD) or State Licensed Healthcare Professional*																		
16. Printed Name	17. Phone Number	18. Date																

*In California, effective April 1, 2025, RDs are permitted to complete and sign a written medical statement for school meal modifications due to a disability. The CDE also permits the following state licensed healthcare professionals to complete and sign a written medical statement for a disability: licensed physicians, physician assistants, and nurse practitioners.

*This form is also considered valid with a certified digital signature.
The information on this form is required to reflect the current medical and/or nutritional needs of the child.

Instructions

1. **School:** Print the name of the school that is providing the form to the parent/guardian.
2. **Site:** Print the name of the site where meals will be served.
3. **Site Phone Number:** Print the phone number of site where meal will be served.
4. **Name of Child:** Print the name of the child to whom the information pertains.
5. **Age of Child:** Print the age of the child. For infants, please use date of birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the child's medical statement.
7. **Phone Number:** Print the phone number of parent/guardian.
8. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child's diet.
9. **Explanation of Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by the RD or state licensed healthcare professional.
10. **Indicate Texture:** If the child does not need any modification, check "Regular".
11. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child with dining (e.g., sippy cup, large handled spoon, wheelchair accessible furniture, etc.).
12. **Foods to be Omitted:** List specific foods that must be omitted.
Suggested Substitutions: List specific foods to include in the diet.
13. **Milk/Dairy Allergy Specifications:** Check boxes for foods students cannot eat
14. **Egg Allergy Specifications:** Check boxes for foods students cannot eat
15. **Signature of RD or State Licensed Healthcare Professional:** Signature of RD or state licensed healthcare professional requesting the special meal or accommodation.
16. **Printed Name:** Print name of RD or state licensed healthcare professional.
17. **Phone Number:** Phone number of RD or state licensed healthcare professional.
18. **Date:** Date RD or state licensed healthcare professional signed the form.

Definitions

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

Physical or mental impairment means, any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disability.

Physical or mental impairment includes, but is not limited to, contagious and noncontagious diseases and conditions such as the following: orthopedic, visual, speech, and hearing impairments, and cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disability, emotional illness, dyslexia and other specific learning disabilities, Attention Deficit Hyperactivity Disorder, Human Immunodeficiency Virus infection (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, writing, communicating, interacting with others, and working; and the operation of a major bodily function.

Major bodily function includes, the operation and functions of the immune system, special sense organs and skin, normal cell growth, and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive systems. The operation of a major bodily function includes the operation of an individual organ within a body system.

USDA Nondiscrimination Statement

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Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, 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 at: <https://www.usda.gov/sites/default/files/documents/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.