RICHLAND ONE
NUTRITION SERVICES

Medical Statement

Parent/Guardian: You have requested a meal accommodation for your child that cannot be achieved within the federal meal pattern requirements for school meals (SP 59-2016). Therefore, in order to meet your child's needs, this form must be completed and returned to the school. The form must be completed by a State Licensed Health Care Professional (Physician (MD or DO), Physician's Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor. A Licensed Medical Nutrition Therapist (LMNT) may also complete and sign when acting under the consultation of the licensed physician.

Name of Child:		Date of Birth:
Name of Parent/Guardian:		Telephone:
Address:	City:	State/Zip:
Email Address:	School Building Child Attends:	Grade:
Description of student's physical or mental impairment that restricts the diet:		
Specify any dietary restrictions or special instructions for meals:		
If applicable, list foods to omit:	If applicable, list foods to substitute:	
Texture Modifications:	Thickness Modifications:	
Signature of State Licensed Health Care Professional:	Name of referring physician working with LMNT *(if applicable):*	
Printed Name and Title:	Phone Number:	Date:

Non-Discrimination Statement: n accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a 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
   Washington, D.C. 20250-9410;
2. fax: (202) 690-7442; or
3. email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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NUTRITION SERVICES

Request for Meal Accommodation

This form may be used to request meal modifications for students who have a physical or medical impairment and participate in the National School Lunch & School Breakfast Programs. The district will work collaboratively with parents to ensure equal opportunity to participate in the School Meal Programs and receive program benefits. However, if the district is unable to accommodate your student's request within the meal pattern requirements; a *Medical Statement* completed by a State licensed Medical Professional will be needed (SP 59-2016).

Parent/Guardian:

Completing the *Request for Meal Accommodation* form helps the school provide meal modifications within the meal pattern requirements for students with a mental or physical impairment. Your participation in this process is very important and communication with the school team allows for advanced planning and preparation needed to provide the accommodation. The district is not required to provide a specific substitution (such as a particular brand name), but offer a reasonable modification that effectively accommodates your child's needs.

Name of Child:		Date of Birth:
Name of Parent/Guardian:		Telephone:
Address:	City:	State/Zip:
Email Address:	School Building Child Attends:	Grade:
Describe the student's physical or mental impairment:		
Specify any dietary restrictions or special instructions for meals:		
Signature of Parent/Guardian:		Date:
IMPORTANT: *The only fluid cow's milk substitutions allowed by USDA are (1) Lactose-free fluid cow's milk or (2) a non-dairy beverage with a nutrient profile equivalent to fluid cow's milk as specified in federal regulations. To see the non-dairy beverages that meet the this requirement visit link to milk requirements*		

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Request to Omit Fluid Cow's Milk

Student Name: _____ District: _____

Birth Date: _____ School: _____

Parent Name: _____ School Contact: _____

Address: _____ School Address: _____

Phone: _____ School Phone: _____

To be completed by a recognized medical authority such as a physician, physician's assistant, nurse practitioner OR by a parent/guardian.
The school is not required to provide substitutions for a milk allergy, lactose intolerance, or for any other non-medical reason, and is permitted to do so **only** when omitted foods and appropriate substitutions are specified by a recognized medical authority or parent/guardian. If diet modifications are implemented by the school, they will continue until either a recognized medical authority or a parent/guardian specifies that they should be changed or stopped. Parents/guardians are encouraged to annually provide updated instructions for diet modifications from a recognized medical authority or a parent/guardian.

Dietary Accommodations: Select one.

☐ **Lactose Intolerance – Please offer student:**
☐ Lactose-free milk ☐ Milk substitute approved by USDA

OR

☐ **Milk allergy – Instead of fluid cow's milk, please offer student:**
☐ Milk substitute approved by USDA (Use Form 21-E to list specific omissions and substitutions)

OR

☐ **Religious, ethical or cultural reasons – Instead of fluid cow's milk, please offer student:**
☐ Milk substitute approved by USDA

Certification:
I certify that the student named on this form needs the prescribed fluid cow's milk omission and substitution(s) due to his/her milk allergy or lactose intolerance(s).

_____ _____ _____
Medical Authority's Signature Phone Number Date

OR

I hereby give permission for the school staff to omit fluid cow's milk and make the above identified substitution(s) in my child's school meals.

_____ _____ _____
Parent/Guardian's Signature Phone Number Date

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