

Medical Statement to Request Special Meals and/or Accommodations

Federal law and USDA regulation require Child Nutrition Programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal dietary preferences.

Site/Provider Name: _____	Submit this form to: _____
-------------------------------------	--------------------------------------

Part I To be completed by Parent/Guardian, Adult Participant, or Organization

Name of Participant: _____	
Parent/Guardian Name: _____	Phone #: _____

Part II To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law* or a Registered Dietitian** (CACFP and SNP only).

1. Describe the major life activity or major bodily function(s) affected by the participant's physical or mental impairment that restricts the diet:
2. Meal Accommodation Plan (Foods to omit or avoid):
3. Foods to be substituted and recommended alternatives (include modification and accommodation):
Signature of State Licensed Health Care Professional* or Registered Dietitian**: _____
Printed Name Signature Date

Part III Organization Use Only

Accommodation(s) Made: _____	
Sponsor Signature: _____	Date _____

Instructions for completing the Medical Statement:

1. **Organization Name:** Include the name of the sponsoring organization that is providing the form
2. **Site/Provider Name:** Print the name of the site where meals will be served (e.g., ABC School, XYZ Child Care Center)
3. **Submit this form to:** Include the name and contact information for the organization staff who will be collecting the completed form
4. **Part I:** This section can be completed by the **Parent/Guardian, Adult Participant, or Organization**
 - a. **Name of Participant:** Print the first and last name of the child or adult participant
 - b. **Parent/Guardian Name:** Print the first and last name(s) of the parent or guardian. This is not required for adult participants.
 - c. **Phone #:** Include a number for the parent/guardian in case of questions
5. **Part II:** This section must be completed by a **State licensed health care professional* or Registered Dietitian**:**
 - a. In section 1 – **Describe:** The major life activity or major bodily function affected by the participant's physical or mental impairment that restricts the diet.
 - b. In section 2 – **Meal Accommodation Plan:** Provide any foods to omit or avoid.
 - c. In section 3 – **Foods to be substituted and recommended alternatives:** Provide the modification and accommodation.
6. **Part III:** This section must be completed by the sponsoring organization after Parts I and II are completed.
 - a. **Accommodations Made:** The sponsoring organization staff will indicate what accommodations will be made for the requests made in Part II.
 - b. **Sponsor Signature and Date:** The sponsoring organization staff will sign and date the form. This form will be considered incomplete if this section is not filled in.

This form is only for participants requiring a medical meal accommodation and should be filled out by a state licensed medical professional* or Registered Dietitian**. Participants requesting a Non-Medical Meal Accommodation and/or a Milk Substitution will use the Meal Preference Request Form.

***State License Health Care Professionals** include: Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified Nurse Practitioner(CNP) or Clinical Nurse Specialist (CNS) Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD).

****Registered Dietitian (RD/RDN)** are authorized by USDA in 7 CFR 210.10(m) and 7 CFR 226.20(g)(1) to complete and sign medical statements for SNP and CACFP participants.