MEDICAL MEALS ACCOMMODATION FORM

This form is for medical purpose only, not dietary preferences.

1. Name of Student	2. Student ID #:	3. Date of Birth	4. ☐ New ☐ Revised ☐ Renewal
5. School *(For Pre-K please state AM, PM, FD)*	6. Grade:		
7. Name of Parent or Guardian	8. Telephone Number and/or Email Address:		

9. Description of child's physical or mental impairment requiring a meal accommodation:

10. Diet prescription and/or accommodation: *(Please describe in detail to ensure proper implementation). Please note: If you are requesting an allergy accommodation, please state ingredients (i.e. wheat, cheese, etc) and not whole foods (i.e. pizza, chicken nuggets, ketchup, etc).*

11. Check ONLY 1 box if texture modification is required after evaluation by State Licensed Healthcare Professional. If N/A, please skip

☐ Level 4 ☐ Level 5 ☐ Level 6 ☐ Level 7

12. Adaptive Equipment:

13. Is the condition life threatening: ☐ Yes ☐ No	14. Epi-Pen Prescribed: ☐ Yes ☐ No

15. List food allergies/intolerances below:

A. OMIT:	B. SUBSTITUTIONS:
☐ Milk ☐ Cheese ☐ Baked Goods/Foods containing Dairy ☐ Whole Eggs (Egg Patty, Scrambled Eggs) ☐ Baked Goods/Foods containing Eggs ☐ Wheat ☐ Sesame ☐ Peanuts ☐ Tree Nuts ☐ Whole Soybeans ☐ Baked Goods/Foods containing Soy ☐ Fish ☐ Shellfish ☐ Other (Specify ingredients not whole foods) _____	☐ Soy Milk ☐ Lactose-Free Milk *Please Note:* Soy and lactose-free milk are the only nutritionally equivalent substitutions for milk per the USDA guidelines that SAUSD Nutrition Services abides by unless otherwise noted by licensed healthcare professional.

16. Signature of State Licensed Healthcare Professional**

17. Printed Name(please include professional credentials)	18.Telephone Number	19.Date

**For this purpose, the CDE only permits the following state licensed healthcare professionals: licensed physicians, physician assistants, and nurse practitioners. Starting 7/1/25, registered dietitians are also permitted to sign the form.

This form **must** be updated **immediately** if there is a change in the medical and/or nutritional needs of the student.

District Use Only:
Please compose 1 **EMAIL** to send completed forms to the following individuals to avoid processing delays:
Registered Dietitians: elizabeth.donis@sausd.us, tracey.roussel@sausd.us, jennifer.chavez@sausd.us, special.meals@sausd.us **School Site Nurse(s)**: See Directory
School Site Cafeteria Supervisor/Lead(s): See Directory

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS INSTRUCTIONS

***Please ensure form is filled out in its entirety or it may be returned which will result in processing delays.**

1. **Name of Student**: Print the name of the student to whom the information pertains.
2. **Student ID #**: Print student's ID number.
3. **Date of Birth:** Print the date of birth of the student.
4. **New, Revised, Renewal:** Please mark if this is a new medical statement, a revised medical statement, or renewal.
5. **School:** Print the name of the site where meals will be sent. If student attends Pre-K, please indicate: AM, PM, FD (Full Day)
6. **Grade:** Print student's grade level for current school year.
7. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
8. **Telephone Number and/or Email Address:** Print the telephone number and/or email address of parent or guardian.
9. **Description of child's physical or mental impairement requiring an accommodation**. Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
10. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For food allergy accomodations, please state ingredients, (i.e. milk, cheese, wheat, etc) **NOT** whole foods (i.e. pizza, ketchip, chicken nuggets, etc).
11. **Select required IDDSI texture modification following evaluation by State Licensed Healthare Professional:** Check (✓) ONLY 1 box to indicate the IDDSI level. IDDSI Levels: Level 4-Pureed, Level 5-Minced & Moist, Level 6-Soft & Bite-Sized, Level 7-Easy to Chew/Regular. If the student does not need any modification, please skip this box.
12. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
13. **Is the condition life threatening:** Check (✓) yes or no.
14. **Is Epi-Pen prescribed:** Check (✓) yes or no.
15. **A. OMIT:** List or check (✓) specific foods that must be omitted.
    B. SUBSTITUTIONS: Please only fill this out if a milk substitution is required. Check (✓) the appropriate milk substitution to include in the diet. *Please note:* Soy and lactose-free milk are the only nutritionally equivalent substitutions per USDA guidelines, unless otherwise noted
16. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional (licensed physicians, physician assistants, nurse practitioners) requesting the accommodation. Starting 7/1/25, registered dietitians are also permitted to sign the form. Please include professional credentials.
17. **Printed Name:** Print or stamp the name of state licensed healthcare professional.
18. **Telephone Number:** Telephone number of state licensed healthcare professional.
19. **Date:** Date medical authority signed form.

DEFINITIONS*:

"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, including 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.

"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.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410 or call (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339, or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

Reference: U.S. Department of Agriculture Food and Nutrition Service Policy Number: SNP-07-2024
https://www.cde.ca.gov/ls/nu/sn/mbsnp072024.asp