NATOMAS UNIFIED SCHOOL DISTRICT NUTRITION SERVICES
MEDICAL STATEMENT TO REQUEST
SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY: ***NATOMAS UNIFIED SCHOOL DISTRICT***	2. SCHOOL SITE:	3. SITE TELEPHONE NUMBER:
4. NAME OF PARTICIPANT:		5. AGE OR DATE OF BIRTH:
6. NAME OF PARENT OR GUARDIAN:		7. TELEPHONE NUMBER:
8. MEALS EATEN AT SCHOOL: ☐ Breakfast ☐ Lunch ☐ Snack ☐ Supper		

Healthcare Professional (Licensed Physician, Physician Assistant Nurse Practitioner, or Registered Dietitian): Complete the Following sections (9-21) **(NOTE: ALL SECTIONS MUST BE COMPLETED BEFORE A MODIFIED MEAL CAN BE PROVIDED)**

9. CHECK ONE:

☐ Participant has a disability or a medical condition and requires a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment.

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons.

10. DISABILITY OR MEDICAL CONDITION REQUIRING A SPECIAL MEAL OR ACCOMMODATION:

11. IF PARTICIPANT HAS A DISABILITY, PROVIDE A BRIEF DESCRIPTION OF PARTICIPANT'S MAJOR LIFE ACTIVITY AFFECTED BY THE DISABILITY:

12. DIET PRESCRIPTION AND/OR ACCOMMODATION: *(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)*

13. INDICATE TEXTURE:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. FOODS TO BE OMITTED AND SUBSTITUTIONS: *(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)*

A. Foods To Be Omitted	B. Suggested Substitutions

15. ADAPTIVE EQUIPMENT:

Complete these sections only if applicable to this student

16. Milk/Dairy Allergy or Intolerance: This student is **NOT** able to eat/drink the following **(Check all that Apply)**

☐ Fluid Cow's Milk ☐ Lactose Free Cow's Milk ☐ Baked Goods Containing Milk/Dairy Products
☐ Yogurt ☐ Cheese ☐ Condiments Containing Milk/Dairy Products

17. Egg Allergy or Intolerance: This student is **NOT** able to eat/drink the following **(Check all that Apply)**

☐ Scrambled Eggs/Egg Patties ☐ Baked Goods Containing Eggs
☐ Condiments Containing Eggs (Mayonnaise, Salad Dressings, etc.)

18. SIGNATURE OF HEALTHCARE PROFESSIONAL:*	19. PRINTED NAME:	20. TELEPHONE NUMBER:	21. DATE:

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, a nurse practitioner, or a registered dietitian.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

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; 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.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowl, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

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

In 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 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 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: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all 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 mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 2050-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Meals Eaten at School:** Check (✓) box next to meals the child will eat from school.
9. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
10. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
11. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
12. **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 example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
13. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
14. **A. Foods to Be Omitted:** List specific foods that must be omitted. For example, the "exclude fluid milk."

    B. Suggested Substitutions: List specific foods to include in the diet. For example, "calcium fortified juice."
15. **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.)
16. **Milk & Dairy Allergy or Intolerance:** If it applies, Check (✓) all boxes the student will **NOT** be able to eat/drink.
17. **Egg Allergy or Intolerance:** If it applies, Check (✓) all boxes the student will **NOT** be able to eat/drink.
18. **Signature of Healthcare Professional:** Signature of Healthcare Professional requesting the special meal or accommodation.
19. **Printed Name:** Print name of Healthcare Professional.
20. **Telephone Number:** Telephone number of Healthcare Professional.
21. **Date:** Date Healthcare Professional signed form.