

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number	
4. Name of Child or Adult Participant		5. Age or Date of Birth	
6. Name of Parent or Guardian		7. Telephone Number	
8. Check One: <input type="checkbox"/> Participant has a disability or a medical condition that requires a special meal and/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. <input type="checkbox"/> Participant does not have a disability, but is requesting a special meal or accommodation due to a food intolerance or other medical reason. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. A licensed physician, physician assistant, or a nurse practitioner must complete and sign this form.			
9. The participant's disability or medical condition requiring a special meal or accommodation:			
10. If participant has a disability, provide a brief description of his/her major life activity affected by the disability:			
11. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):			
12. Indicate food texture for above participant: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed			
13. Foods to be omitted and substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):			
A. Foods To Be Omitted		B. Suggested Substitutions	
_____		_____	
_____		_____	
_____		_____	
14. Adaptive equipment to be used:			
15. Signature of Recognized Medical Authority*		16. Printed Name	17. Telephone Number
			18. Date

*For this purpose, a recognized medical authority in California is a licensed physician, physician assistant, or a nurse practitioner.

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

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