Child Nutrition Programs
Medical Statement to Request Special Meals and/or Accommodations

A recognized Medical Authority must fill out a Medical Statement to Request Special Meals and/or Accommodations form and return it to the school, child or adult care facility/provider. Agencies have an obligation to provide alternate foods to those participants who meet any of the following definitions.

Definitions:

"A person with a disability" is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such 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, specific learning disabilities.

"**Major life activities"** are defined as "functions such as 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, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions."

"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.

"Recognized Medical Authority" means state recognized medical professional with prescriptive authority such as, licensed physician, physician's assistant, or nurse practitioner.

The medical statement shall identify:

- The participant's disability or medical condition with an explanation of why the disability restricts the participant's diet;
- The major life activity affected by the disability;
- The specific diet or accommodation that has been prescribed by the medical authority. For example: "All foods must be in liquid or pureed form. Participant cannot consume any solid foods."
- The type of texture of food that is required,
- The specific foods that must be omitted and suggested substitutions
- The specific equipment required to assist the participant with dining. Examples might include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

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***Form must be signed by state recognized medical professional with prescriptive authority such as, licensed physician, physician's assistant, or nurse practitioner. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.**

1. School/Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Participant		5. Age or Date of Birth
6. Name of Parent of Guardian		7. Telephone Number
8. Description of Child's Physical or Mental Impairment Affected:		
9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation: *(please describe in detail to ensure proper implementation-use extra pages as needed)*		

10. 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. Food To Be Omitted:	**B. Suggested Substitutions:**
_____	_____
_____	_____
_____	_____
_____	_____

11. Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

12. Adaptive Equipment to be Used:			
12. Adaptive Equipment to be Used:	14. Printed Name	15. Phone Number	16. Date
17. Signature of Medical Authority*	18. Printed Name	19. Phone Number	20. Date

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS 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, child care center, community center, etc.)
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. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child's diet.
9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribe by the state healthcare professional.
10. A. **Foods to Be Omitted:** List specific foods that must be omitted. (e.g., exclude fluid milk.)
    B. **Suggested Substitutions:** List specific foods to include in the diet. (e.g., calcium fortified juice.)
11. **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".
12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the participant with dining. (e.g., a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
13. **Signature of Preparer:** Signature of person completing form.
14. **Printed Name:** Print name of person completing form.
15. **Telephone Number:** Telephone number of person completing form.
16. **Date:** Date preparer signed form.
17. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
18. **Printed Name:** Print name of medical authority.
19. **Telephone Number:** Telephone number of medical authority.
20. **Date:** Date medical authority signed form.

The American with Disabilities Act Amendment Act defines a "disability", in part, as a physical or mental impairment that substantially limits a major bodily function of an individual.

(For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008)

Information regarding the ADAAA, which expanded the definition of disability, can be found at:
http://www.law.georgetown.edu/archiveada/documents/comparisonofADAandADAAA.pdf

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

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS

Non-Discrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"