MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Please complete this form and return the ORIGINAL to cafeteria staff or to Child Nutrition Services office at 250 Church Street, Redlands, CA 92374

1. District Name	2. School Name	3. School Telephone Number
Redlands Unified School District		

4. Student Name	5. Permanent Student ID #	6. Date of Birth	7. Grade

8. Name of Parent or Guardian	9. Telephone Number	10. Meals Needed
		☐Breakfast ☐Lunch ☐Snack ☐Supper

11. 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. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. 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's assistant, or nurse practitioner must sign this form.**

12. Disability or medical condition requiring a special meal or accommodation:

13. If student has a disability, provide a brief description of student's major life activity affected by the disability:

14. DIET PRESCRIPTION AND/OR ACCOMMODATION: (*Please describe in detail to ensure proper implementation-use extra pages as needed*)

15. Indicate any texture modifications required:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

16. Is the condition life threatening:	17. Epi-pen Prescribed:
☐ Yes ☐ No	☐ Yes ☐ No

18. Attach a copy of special diet OR list food allergies/intolerances below:

OMIT the following: (check all that apply)

Dairy: ☐Fluid Milk ☐All Dairy Products Containing Lactose ☐All Foods with Dairy Protein (Casein/Whey)
Egg: ☐Whole Eggs ☐Egg Yolk ☐Egg White ☐All Foods Containing Egg
Wheat/Grains: ☐All Wheat Products ☐All Gluten Containing Products (Wheat, Oats, Rye, Barley)
Nuts: ☐Peanuts ☐Tree Nuts (Walnuts, Almond) ☐Seeds (Sesame, Sunflower)
Soy: ☐Soy Beans (Edamame) ☐All Soy Ingredients
Fish: ☐All Fish ☐Shellfish
Fruit/Juices: ☐Citrus ☐Fruit ☐Strawberries ☐Other:
Other: Allergies (if applicable): _____

_____

_____

Suggested Substitutions:(Please Note: Juice is not an approved substitute for Milk under USDA guidelines)

_____

_____

19. Indicate Adaptive Equipment (if required):

20. Signature of Preparer	21. Printed Name	22. Telephone Number	23. Date

24. Signature of Medical Authority*	25. Printed Name	26. Telephone Number	27. Date

*** Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.**

District Use ONLY: (Initial to confirm receipt)

Nutrition Manager/Specialist:_____ School Nurse: _____

INSTRUCTIONS

1. **School/Agency:** Redlands USD prefilled, nothing more required.
2. **School:** Print the name of the school where meals will be served.
3. **School Telephone Number:** Print the telephone number of school where meal will be served. See #2.
4. **Name of Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Student ID:** Print student's identification number.
6. **Age of Student:** Print the age of the students. For infants, please use date of birth.
7. **Grade:** Print grade of student.
8. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
9. **Telephone Number:** Print the telephone number of parent or guardian.
10. **Meals Needed:** Please check (✓) the meals that the student will eat at school on a daily basis.
11. **Check One:** Check (✓) a box to indicate whether student has a disability or does not have a disability.
12. **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.).
13. **If Student 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 (e.g., Allergy to peanuts causes a life-threatening reaction).
14. **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 (e.g., All foods must be either in liquid or pureed form. Participant cannot consume any solid foods).
15. **Indicate any Texture Modifications Required:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
16. **Is the condition life threatening:** Check (✓) yes or no.
17. **Is Epi-Pen prescribed:** Check (✓) yes or no.
18. **A. Foods to Be Omitted:** List or check (✓) specific foods that must be omitted.
    B. Suggested Substitutions: List specific foods to include in the diet.
19. **Indicate Adaptive Equipment if Required:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
20 **Signature of Preparer:** Signature of person completing form.
21. **Printed Name:** Print name of person completing form.
22. **Telephone Number:** Telephone number of person completing form.
23. **Date:** Date preparer signed form.
24. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
25. **Printed Name:** Print name of medical authority.
26. **Telephone Number:** Telephone number of medical authority.
27. **Date:** Date medical authority signed form.

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 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, bowel, 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.

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