**Idaho State Department of Education**
**Child Nutrition Programs**

# MEDICAL STATEMENT:

## *Request for Special Meals and/or Accommodations*

| (1) Name of Participant | (2) Age or DOB | (3) Sponsor | (4) Site |
|---|---|---|---|
| | | | |
| **(5) Name of Parent /Guardian, or Auth. Rep.** | **(6) Telephone (Parent /Guardian, or Auth. Rep.)** ( ) | | **(7) Site Telephone Number** ( ) |

**(8) Must check one:**

☐ Participant is disabled or has a medical condition and *requires* a special meal or accommodation. (Refer to definition on reverse side of this form.) Sponsors must comply with requests for special meals and any adaptive equipment. **A licensed physician, physician assistant, nurse practitioner, or dentist must sign this form**.

☐ Participant is not disabled, but is *requesting* a special meal or accommodation. An example may include food intolerances, and is not intended to include food preferences. Sponsors are encouraged to accommodate reasonable requests. **A licensed physician, physician assistant, nurse practitioner, registered dietitian, or registered nurse must sign this form.**

**(9) Disability or medical condition requiring a special meal or accommodation:** _____

_____

**(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability:**

_____

_____

**(11) Diet prescription and/or accommodation:** (Please describe in detail to ensure proper implementation) _____

_____

**(12) Indicate texture:** ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

**Foods to be omitted and substitutions:** Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

| **(13) Foods to be omitted** | **(14) Suggested substitutions** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**(15) Adaptive Equipment:** _____

| (16) Signature of Preparer* | (17) Printed Name | (18) Telephone ( ) | (19) Date |
|---|---|---|---|
| **(20) Signature of Medical Authority*** | **(21) Printed Name** | **(22) Telephone** ( ) | **(23) Date** |
| **(24) Signature of Parent/Guardian** | **(25) Printed Name** | **(26) Telephone** ( ) | **(27) Date** |

** Participants with a disability require a signature from a physician, physician assistant, nurse practitioner, or dentist. For non-disabled participants, a licensed physician, physician assistant, nurse practitioner, registered dietitian or registered nurse must sign the form.*

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

***This institution is an equal opportunity provider.***

**INSTRUCTIONS: Fill in the fields with the following information**

1) Name of participant: Individual who will receive the meal
2) Age of participant: For infants, please use DOB (Date of Birth).
3) Sponsor: Name of the Child Nutrition Program under which meal will be served
4) Site: Site where meal will be served (e.g., school site, child care center, community center, etc.)
5) Name of Participant's Parent, Guardian, or Authorized Representative: individual responsible for the care of participant in CNP program
6) Telephone: Telephone number of guardian, parent, or authorized representative.
7) Site Telephone: Telephone number of site where meal will be served. See #4.
8) Check Box: Check whether participant is disabled or not disabled.
9) Disability or Medical Condition Requiring a Special Meal: Describe medical condition that requires a special meal or accommodation. (E.g., juvenile diabetes, allergy to peanuts).
10) Provide a Brief Description of Participant's Major Life Activity Affected by Disability: Describe how physical condition affects disability. For example: "Allergy to peanuts causes anaphylactic shock which causes trouble breathing, choking, and potential death unless epinephrine injection is given immediately to the child and the child is sent to the emergency room for follow-up treatment."
11) Diet Prescription and/or Accommodation: Describe 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. Child cannot consume any solid foods."
12) Indicate Texture: Check the type of texture of food that is required. If the participant does not need any modification check "regular".
13) Foods to be Omitted: List specific foods that must be omitted. For example, "exclusion of fluid milk."
14) Suggested Substitutions: List specific foods to include in the diet. For example, "lactose reduced milk, calcium fortified juice."
15) Adaptive Equipment: Describe specific equipment required to feed the participant. (Examples may include tippy cup, large handled spoon, wheel-chair accessible furniture, etc.)
16) Signature of Preparer: Signature of person completing form.
17) Printed Name: Print name of person completing form.
18) Telephone: List telephone number of person completing form.
19) Date: indicate when form was completed
20) Signature of medical authority: Signature of medical authority requesting the special meal or accommodation.
21) Printed Name: Print name of medical authority.
22) Telephone: Telephone number of medical authority.
23) Date: Indicate when form was completed
24) Signature of parent/guardian
25) Printed Name: Print name of parent/guardian.
26) Telephone: Telephone number of parent/guardian.
27) Date: Indicate when form was completed

**Definitions**

**"Disabled person"** 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 an impairment, or is regarded as having such an impairment.

**"Physical or mental impairment"** means (1) 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; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

**"Major life activities"** are functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. **"**Has a record of such an impairment" is defined as having a history of, or has been classified as having a mental or physical impairment that substantially limits one or more major life activities.

Idaho State Department of Education
Child Nutrition Programs

Example: Medical Condition **IS** a Disability

# MEDICAL STATEMENT:

## *Request for Special Meals and/or Accommodations*

| (1) Name of Participant | (2) Age or DOB | (3) Sponsor | (4) Site |
|---|---|---|---|
| Rosey Apple | 10/01/2010=4 yrs. | Riverglen Day Care | Oakmont Street |
| **(5) Name of Parent, Guardian, or Auth. Rep.** | **(6) Telephone (Parent , Guardian, or Auth. Rep.)** | | **(7) Site Telephone Number** |
| Myra Apple | (707 ) 555-4321 | | (707 ) 555-0692 |

**(8) Must check one:**

☒ Participant is disabled or has a medical condition and *requires* a special meal or accommodation. (Refer to definition on reverse side of this form.) Sponsors must comply with requests for special meals and any adaptive equipment. **A licensed physician, physician assistant, nurse practitioner, or dentist must sign this form**.

☐ Participant is not disabled, but is *requesting* a special meal or accommodation. An example may include food intolerances, and is not intended to include food preferences. Sponsors are encouraged to accommodate reasonable requests. **A licensed physician, physician assistant, nurse practitioner, registered dietitian, or registered nurse must sign this form.**

**(9) Disability or medical condition requiring a special meal or accommodation:** Rosey is allergic to soybeans.

**(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability:**

This disability is a life-threatening condition. Consuming soybeans can cause Rosey to go into shock requiring an injection of epinephrine and immediate medical attention.

**(11) Diet prescription and/or accommodation:** (Please describe in detail to ensure proper implementation.)

Exclusion of all soybeans and soybean products

**(12) Indicate texture:** ☒ Regular ☐ Chopped ☐ Ground ☐ Pureed

**Foods to be omitted and substitutions:** Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

| (13) Foods to be omitted | (14) Suggested substitutions |
|---|---|
| Alternate Protein Products (such as TVP, VPP) | Hamburger, ground turkey or beef, chicken |
| Soy milk, | Cow's milk -white or chocolate |
| Soy oil, soy sauce or soy flour | Peanut, corn, or safflower oils |
| Soy flour | White or whole wheat flour |

**(15) Adaptive Equipment**: N/A

| (16) Signature of Preparer* | (17) Printed Name | (18) Telephone | (19) Date |
|---|---|---|---|
| Trish Smith, RN | Trish Smith, RN | (313) 555-2222 | 04/15/15 |
| **(20) Signature of Medical Authority*** | **(21) Printed Name** | **(22) Telephone** | **(23) Date** |
| Robert Cisneros, MD | Robert Cisneros | (313) 555-2222 | 04/15/15 |
| **(24) Signature of Parent/Guardian** | **(25) Printed Name** | **(26) Telephone** | **(27) Date** |
| Myra Apple | Myra Apple | (313) 555-4321 | 04/15/15 |

** Participants with a disability require a signature from a physician, physician assistant, nurse practitioner, or dentist. For non-disabled participants, a licensed physician, physician assistant, nurse practitioner, registered dietitian or registered nurse must sign the form.*

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

Idaho State Department of Education
Child Nutrition Programs

Example: Medical Condition IS **NOT** a Disability

# MEDICAL STATEMENT:

## *Request for Special Meals and/or Accommodations*

| (1) Name of Participant | (2) Age or DOB | (3) Sponsor | (4) Site |
|---|---|---|---|
| *Kendra Tung* | *16 years* | *Harte School District* | *Hartnell School* |
| **(5) Name of Parent, Guardian, or Auth. Rep.** | **(6) Telephone (Parent , Guardian, or Auth. Rep.)** | | **(7) Site Telephone Number** |
| *Leona Tung* | **(854) 555-3211** | | **(854) 555-0112** |

**(8) Must check one:**

☐ Participant is disabled or has a medical condition and *requires* a special meal or accommodation. (Refer to definition on reverse side of this form.) Sponsors must comply with requests for special meals and any adaptive equipment. **A licensed physician, physician assistant, nurse practitioner, or dentist must sign this form**.

☒ Participant is not disabled, but is *requesting* a special meal or accommodation. An example may include food intolerances, and is not intended to include food preferences. Sponsors are encouraged to accommodate reasonable requests. **A licensed physician, physician assistant, nurse practitioner, registered dietitian, or registered nurse must sign this form.**

**(9) Disability or medical condition requiring a special meal or accommodation:** *Lactose intolerance*

**(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability:**

**(11) Diet prescription and/or accommodation:** (Please describe in detail to ensure proper implementation.)

*Exclusion of fluid milk*

**(12) Indicate texture:** ☒ Regular ☐ Chopped ☐ Ground ☐ Pureed

**Foods to be omitted and substitutions:** Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

| (13) Foods to be omitted | (14) Suggested substitutions |
|---|---|
| Milk | Lactose-free milk, calcium-fortified juice |
| | Fruited yogurt |
| | |

**(15) Adaptive Equipment:** N/A

| (16) Signature of Preparer* | (17) Printed Name | (18) Telephone | (19) Date |
|---|---|---|---|
| *Lynda Philess, RD* | **Lynda Philess, RD** | **(707) 555-0897** | **04/01/15** |
| **(20) Signature of Medical Authority*** | **(21) Printed Name** | **(22) Telephone** | **(23) Date** |
| *Lynda Philess, RD* | **Lynda Philess, RD** | (707) 555-1661 | 04/01/15 |
| **(24) Signature of Parent/Guardian** | **(25) Printed Name** | **(26) Telephone** | **(27) Date** |
| *Leona Tung* | **Leona Tung** | (854) 555-3211 | 04/01/15 |

** Participants with a disability require a signature from a physician, physician assistant, nurse practitioner, or dentist. For non-disabled participants, a licensed physician, physician assistant, nurse practitioner, registered dietitian or registered nurse must sign the form.*

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