Ellsworth - Kanopolis - Geneseo USD # 327

Date: _____

Dear_____,

Your child's school:

1. Will make meal modifications prescribed by a licensed physician to accommodate a disability.
2. Will make meal modifications prescribed by a medical authority due to a food allergy/intolerance or other medical condition that does not rise to the level of a disability.
3. Will make substitutions for fluid cow's mile due to a food allergy/intolerance or for other reasons.

The *Medical Statement to Request School Meal Modification* is attached to this letter. On the front of this form there is further information about the three categories of meal modifications that can be requested under federal regulations, and the procedures that apply to each category. Please read this information carefully before completing the form. Only the types of meal modifications explained in the first paragraph of this letter are applicable to your child's school.

To ensure the requested meal modifications can be made on the first day of school, return the completed medical statement as soon as possible to Bonnie Peterman, RN, School Nurse, at the Ellsworth Elementary School.

If you are submitting a request for meal modification at this time other than the beginning of the school year, it will take approximately two business days from the time the request is received until it can be implemented.

IMPORTANT: For a student who does not have a recognized disability, the only fluid cow's milk substitutions allowed by USDA are: (1) lactose-free fluid cow's milk or (2) a non-dairy beverage with a profile equivalent to fluid cow's milk as specified in federal regulations.

If you have any questions or need assistance, please call Bonnie Peterman, RN, School Nurse at 785-472-5554.

Sincerely,

Bonnie Peterman, RN, School Nurse
Ellsworth-Kanopolis-Geneseo USD #327

Medical Statement to Request Meal Modification

Modifications to Accommodate a Disability: Meal modifications prescribed by a medical authority must be made to accommodate a participant's disability.

Definition of Disability: Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability 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. "Major life activities" are broadly defined and 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 life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

This form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (APRN) authorized by their responsible licensed physician.

Part A. Participant, Parent/Guardian, Facility Contact Information – To be completed by a parent/guardian or facility contact person.

Participant's Name:	Date of Birth:	Facility:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
Facility Contact's Name:	Facility Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Description of the physical or mental impairment related to the prescribed diet order and major life activity affected.
   Example: Allergy to peanuts affects ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Special Feeding Equipment _____
(e.g. large handled spoon, sippy cup, etc.)

3. Medical Authority's Information:

Signature: Title:

Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for facility personnel responsible for implementing the prescribed diet order to discuss the special dietary accommodations with any appropriate staff and to follow the prescribed diet order for meals. I also give permission for the medical authority to further clarify the prescribed diet order on this form if requested to do so by facility personnel.

Parent/Guardian's Signature: Date:

This institution is an equal opportunity provider.