C015

Medical Statement Form to Request Special Meals and/or Accommodations

This form may be used to request meal modifications for participants in the Child Nutrition Programs in Nebraska (National School Lunch, Child and Adult Care Food Program, and Summer Food Service Program). There are <u>three types of meal modification requests</u> that can be made using this form (*<u>all request options require the parent or guardian to initially complete Sections 1 to 9 in Part A</u> of the form*):

- **Modification Option # 1:** Used to request **substitution for fluid cow's milk** due to Lactose Intolerance, Vegan, Religious, Cultural, or Ethical Reasons. This request can be made by the parent/guardian completing Sections 10 in Part A of this form. It does not require a physician/medical authority signature or completion of either the Part B or Part C Medical Statement portions of this form. ***<u>Note:</u>*** *The school/agency may at their discretion, offer a nutrient equivalent non-dairy milk substitute for a participant with a medical or special dietary need that is NOT life threatening or considered a disabling condition.*

- **Modification Option #2:** Used to request a **modification due to a disability**, including the potential for a severe allergic reaction (anaphylaxis) to food. Part B, Sections 11 to 22 must be completed by a licensed physician *(M.D. or D.O)*. ***<u>Note:</u>*** *Schools/agencies participating in one or more of the federal programs listed above are required to make accommodations for participants who are unable to eat the regular meals because of a disability that restricts their diet.*

- **Modification Option #3:** Used to request a meal **modification due to a food allergy/intolerance, or other medical condition** that does not rise to the level of a disability. Part C, Sections 21 to 30 must be completed by a Licensed Physician *(MD or DO)*, Physician's Assistant *(PA)*, Advance Practice Registered Nurse-Nurse Practitioner *(APRN-NP)*, or Chiropractor. A Licensed Medical Nutrition Therapist *(LMNT)* also may complete and sign Part C when acting under the consultation of a licensed physician. ***<u>Note:</u>*** *Schools/agencies <u>may</u>, at their discretion, make substitutions for participants who have a special dietary need that does not meet the definition of a disability.*

Parent/Guardian:

The *Medical Statement Form* helps the school/agency provide meal modifications for participants who require them. Your participation in this process is very important. The sooner you provide this signed and completed form to the school/agency, the sooner the staff can prepare the food required. Your signature is required for the school/agency to take action on the medical statement. The school/agency staff cannot change food textures, make food substitutions, or alter the participant's diet without completion of the necessary portions of this form.

Definitions*: *(As used for purposes of medical statements and modification requests on this form)*:

The term **"disability"** means, with respect to an individual: (A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such impairment. *(See 42 U.S.C. 12102)**

The term **"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. The term *physical or mental impairment* includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis, cancer; heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism. *(See 7 CFR 15b. 3(j).)**

The term **"major life activities"** includes, 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. A major life activity also includes the 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. *(See 42 U.S.C. 12102)**

The term **"has a record of such an impairment"** means the participant has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities. *(See 7 CFR 15b. 3(l).)**

The term **"regarded as having such an impairment"**, as defined in USDA federal Food and Nutrition Service regulations at 7 CFR 15b, means that the participant (1) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (2) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others towards such impairments, or (3) has none of the impairments defined in paragraph (j) of this section but is treated by a recipient as having such an impairment. ("Recipient" would be a school/agency receiving nutrition services reimbursement.) *(See 7 CFR 15b. 3(m) and 42 U.S.C. 12102)**

Definitions are based upon the Americans with Disabilities Act Amendments Act of 2008 (See Title 42 of the United State Code, Section 12102), and USDA Food and Nutrition Service regulations (See Title 7 of the Code of Federal Regulations, Part 15b.) Refer to the full texts of these laws and regulations for more detail.

MEDICAL STATEMENT FORM TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

This form is to be used to request meal modification(s) for participants in the National School Lunch Program, Child and Adult Care Food Program, and/or Summer Food Service Program
(See Attached Instructions for Completing this Form)

PART A: Parent/Guardian completes this section – please print.

1. Name of Participant:		2. Date of Birth:
3. Name of Parent/Guardian:		4. Telephone:
5. Address:	6. City:	7. State/Zip:
8. Email Address:		

9. **I give permission** for the school/agency personnel responsible for implementing my child's prescribed diet order to share information with employees in order to accommodate this food modification request at other school/agency activities involving food.

☐ Yes ☐ No

Parent/Guardian Signature: ______________________________ Date:____________

10. **Modification Option #1**. **Milk Substitution Request Only** (If applicable, Parent/Guardian must check box and sign):

☐ Participant is requesting substitution for fluid cow's milk due to lactose intolerance, vegan diet, religious, cultural, or ethical reasons. This milk substitution request can be made by the parent/guardian signing this form.

Parent/Guardian Signature: ____

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 a (2) Non-dairy beverage with a nutrient profile equivalent to fluid cow's milk as specified in federal regulations. Currently, the only beverages meeting these specifications are certain brands of soymilk (8th Continent, Kikkoman Pearl, and Pacific Brand Ultra).*

A physician/medical authority signature and completion of Parts B or C of this form is NOT required if this is the only requested substitution.

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As stated above, all protected bases do not apply to all programs, "*the first six protected bases of race, color, national origin, age, disability and sex are the six protected bases for applicants and recipients of the Child Nutrition Programs.*

PART B: (Modification Option #2) Medical Statement - *For participants with a disability*

Completion of this PART B Medical Statement is required when the modification request is due to a disability, including a potential for a serious allergic reaction to a food (includes anaphylaxis).

To be completed by a licensed physician (M.D. or D.O).

11. ☐ **Disability** (*Specify the disability, food allergy/intolerance or medical condition and explain why the disability restricts the participant's diet.*)

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Check major life activities affected:

☐ Walking ☐ Seeing ☐ Hearing ☐ Speaking ☐ Breathing ☐ Working ☐ Learning
☐ Performing manual tasks ☐ Caring for self (including eating) ☐ Other __________

Check major bodily functions potentially affected (either acutely or long term):

☐ Endocrine ☐ Growth ☐ Respiratory ☐ Neurological ☐ Circulatory ☐ Bladder ☐ Gastrointestinal
☐ Cardiovascular ☐ Reproductive system ☐ Immune system

☐ **Potential for a Serious Allergic Reaction to Food (includes anaphylaxis).** *Specify the food or foods:*

____

12. **Specify any dietary restrictions or special diet instructions for meals:**

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13. If applicable, list the foods to be omitted and substituted in their diet (attach additional sheets if needed):

Foods to be Omitted	Suggested Substitutions

14. Modified Texture:	☐ Not applicable	☐ Chopped	☐ Ground	☐ Pureed
15. Modified Thickness of Liquids:	☐ Not applicable	☐ Nectar	☐ Honey	☐ Pudding Thick
16. Special Feeding Equipment:	If applicable, list special feeding equipment (e.g. large handled spoon, Sippy cup, etc.):			

17. **M.D. or D.O. Signature:** ____________________ 18. **Date:** __________

19. **Printed Name/Title:** ____________________ 20. **Phone:** __________

Participant's Name____________________________

PART C: (Modification Option #3) Medical Statement *(For participants without a disability)*

Completion of this PART C Medical Statement is required when the requested modification is due to a food allergy/intolerance, or other medical condition that does not rise to the level of a disability. *Please note: The school/agency may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need.*

To be completed by a Licensed Physician (MD or DO), or other recognized medical authority for this purpose: Physician's Assistant (PA), Advance Practice Registered Nurse-Nurse Practitioner (APRN-NP), or Chiropractor. A Licensed Medical Nutrition Therapist (LMNT) also may complete and sign Part C when acting under the consultation of a licensed physician. *Please note: LMNT's must list the referring physician in Section 26.*

21. **Diagnosis** *(Specify the food allergy/intolerance or medical condition and explain why it restricts the participant's diet.)*

22. **Specify any dietary restrictions or special diet instructions for meals:**

23. If applicable, list the foods to be omitted and substituted in the diet (attach additional sheets if needed):

Omit Foods Listed Below:	Substitute Foods Listed Below:

24. Modified Texture:	☐ Not applicable	☐ Chopped	☐ Ground	☐ Pureed
25. Modified Thickness of Liquids:	☐ Not applicable	☐ Nectar	☐ Honey	☐ Pudding Thick

26. Signature of Physician/Other Medical Authority/LMNT: ______________________

27. Name of referring physician working with LMNT ***(if applicable):*** ______________________

28. Printed Name and Title: ______________________

29. Phone Number: ______________________

30. Date: ______________________

Participant's Name______________________