Englewood Schools
A Relentless Focus On Learning

Medical Statement for Dietary Disability - Meal Modification

Dear Parent/Guardian:

Concerning your student (s) at Bishop Elementary, Charles Hay World School, Cherrelyn Elementary, Clayton Elementary, Englewood Middle School, Englewood Leadership Academy, Englewood High School and Colorado's Finest High School of Choice

No special meal accommodations will be made for students unless they have a **documented dietary disability as defined below and prescribed by a licensed physician, advanced practice nurse with prescriptive authority or physician assistant to accommodate the disability**. We do not accommodate lactose intolerance unless it rises to the level of dietary disability as described below.

Definition of Disability: Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a "person with a disability" means "any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment."

Major life activities covered by this definition include: caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. Major life activities also includes "Major Bodily Functions" such as: functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions.

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
- Metabolic diseases, such as diabetes or phenylketonuria (PKU)
- Food anaphylaxis (severe food allergy)
- Mental retardation
- Emotional illness
- Drug addiction and alcoholism

In short…

1. **We will make meal modifications** prescribed by a licensed physician, advanced practice nurse with prescriptive authority or physician assistant to accommodate a disability. (See definition above)
2. **We will not make meal modifications** prescribed by a medical authority due to a food allergy/intolerance religious/cultural or other medical condition that does not rise to the level of a disability.
3. **We will not make substitutions for fluid cow's** milk due to a food allergy/intolerance or for other reasons for a medical condition that does not rise to the level of a disability.

The *Medical Statement for Disability- School Meal Modification (SD-1)* form is attached and also available for download from our website, www.englewoodschools.net , in your school's front office, health assistant office, and with your school's Kitchen Manager. On the front of the form there are further instructions and information about the meal modifications that can be requested under federal regulations, and the procedures that apply to an allergy/intolerance that rises to the level of a disability (SD-1). Please make sure that all parts of the form are filled out and signed by the proper medical authority.

Occasionally, a meal modification for a documented disability needs to be changed or discontinued. In the case of a meal modification change, a new SD-1 form is required and filled out by the medical authority (licensed physician/advanced practice nurse with prescriptive authority or physician assistant). In the case of a discontinuation of a meal modification a "Discontinuation of School Meal Modifications" (form SD-3) and filled out by the medical authority (as described above) before food service staff may discontinue the modification.

If you are submitting a request for meal modification due to a disability at a time other than the beginning of the school year, please note that it will take approximately 3 school days from the time the request is received in Food and Nutrition Services until it can be implemented.

If you have questions concerning this matter, need assistance or would like to submit your completed Medical statement for Disability (SD-1), **please contact me or the Health Assistant at your school.** Your completed SD-1 form will be kept on file in the Food and Nutrition Services Central Office as well as in the health assistant's office at your child's school.

Sincerely,

Beth Schwisow M.S., R.D.

Nutrition Services Director

This FNS Department Procedure is based on the USDA's "Accommodating Children with Special Dietary Needs in the School Nutrition Programs-Guidance for School Food Service Staff" Fall 2001 Document.

Revised 8/2015 BEAS, 2/2016 BEAS

Medical Statement for Dietary Disability - School Meal Modification SD-1

Important! Carefully read and follow the procedures for a dietary disability. The school will return incomplete Medical Statements to the parent/guardian. If you have questions about this form, the school contact named in Part A below will assist you. **Modification due to a dietary disability:**

- A school is required to make meal modifications prescribed by a licensed physician, advanced practice nurse with prescriptive authority or physician assistant to accommodate a student's dietary disability.
- If this is a life-threatening food allergy resulting in anaphylaxis, ensure the Allergy & Anaphylaxis Action Plan form is completed by school nursing staff.

Definition of Disability: Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a "person with a disability" means "any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment."

Major life activities covered by this definition include: caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. Major life activities also includes "Major Bodily Functions" such as: functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions. 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
- Metabolic diseases, such as diabetes or phenylketonuria (PKU)
- Food anaphylaxis (severe food allergy)
- Mental retardation
- Emotional illness
- Drug addiction and alcoholism

Filling out Form:

- Part B of this form must be completed by a licensed physician (MD or DO), advanced practice nurse (APN) with prescriptive authority (RXN) or physician assistant (PA).
- Parts A and C of this form must also be completed before the school can make meal modifications.
- The meal modifications will continue until a licensed physician, advanced practice nurse with prescriptive authority or physician assistant requests that the modifications be changed or stopped on Form SD-3, which is available from the school.
- It is strongly recommended that a licensed physician, advanced practice nurse with prescriptive authority or physician assistant annually update the prescribed diet order.

Part A. Student, Parent/Guardian & School Contact Information – To be completed by a parent/guardian or school contact person		
1. Student's Name:	2. Date of Birth:	3. School:
4. Parent/Guardian's Name:	5. Parent/Guardian's Phone:	
6. School Contact's Name:	7. School Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a licensed physician, advanced practice nurse with prescriptive authority or physician assistant as specified above.
1. Specify the disability, food allergy/intolerance or medical condition and explain why the disability restricts the child's diet.
2. What major life activity is affected by this student's disability? Example: Allergy to peanuts affects ability to breathe.

3. Type of Special Diet: ☐ Check if not applicable OR specify the type of special diet (e.g. low sodium, gluten-free, diabetic, etc.).				
4. Modified Texture:	☐ Not Applicable	☐ Chopped	☐ Ground	☐ Pureed
5. Modified Thickness of Liquids:	☐ Not Applicable	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick
☐ 6. Special Feeding Equipment: Check if not applicable OR list special feeding equipment (e.g. large handled spoon, sippy cup, etc.).				
7. Foods to be Omitted and Substituted: List specific foods to be omitted and substituted. If more space is needed, sign and attach additional sheet of paper.				

Omit Foods Listed Below:	Substitute Foods Listed Below:

8. Licensed Physician/Advanced Practice Nurse with Prescriptive Authority/Physician Assistant Information		
Signature:	Title:	
Printed Name:	Phone:	Date:

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

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff. I also give permission for my child's licensed physician, advanced practice nurse with prescriptive authority or physician assistant to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: Date:

Declaración médica de discapacidad alimentaria - Modificación de comidas escolares SD-1

¡Importante! Lea y siga cuidadosamente los procedimientos ante una discapacidad alimentaria. La escuela devolverá las declaraciones médicas que no estén completas al padre, la madre o el tutor. Si tiene alguna pregunta sobre este formulario, la persona de contacto de la escuela que figura en la Parte A que se encuentra a continuación lo ayudará. **Modificaciones debido a una discapacidad alimentaria:**

- Se le exige a la escuela que realice modificaciones en las comidas según indicación de un médico matriculado, asistente médico o practicante avanzado en enfermería matriculado para adaptarlas a la discapacidad alimentaria de un estudiante.
- Si se trata de una alergia alimentaria potencialmente mortal que resulte en anafilaxia, asegúrese de que el personal de enfermería escolar complete el formulario del Plan de acción contra la alergia y la anafilaxia.

Definición de discapacidad:

Según el Artículo 504 de la Ley de Rehabilitación de 1973 y la Ley de Estadounidenses con Discapacidades (Americans with Disabilities Act, ADA), una "persona con discapacidad" significa "cualquier persona que tenga un impedimento físico o mental que limite de forma considerable una o más actividades importantes de la vida, tenga antecedentes de tal impedimento o se considere que tenga dicho impedimento".

Actividades importantes de la vida incluidas en esta definición: atender a sus propias necesidades, comer, realizar tareas manuales, caminar, ver, oír, hablar, respirar, aprender y trabajar. Las actividades importantes de la vida también incluyen las "principales funciones corporales", tales como: funciones del sistema inmune, del crecimiento celular normal, digestivas, intestinales, de la vejiga, neurológicas, cerebrales, respiratorias, circulatorias, cardiovasculares, endócrinas y las funciones reproductivas. El término "impedimento físico o mental" incluye, de manera no taxativa, enfermedades y afecciones, tales como las siguientes:

- Impedimentos ortopédicos, visuales, auditivos y del
- Parálisis Cerebral
- Epilepsia
- Distrofia muscular
- Enfermedades metabólicas, como la diabetes o la (phenylketonuria, PKU)
- Esclerosis múltiple
- Cáncer

- □ Enfermedades cardíacas habla
- □ Anafilaxia alimentaria (alergia alimentaria grave)
- □ Retraso mental
- □ Enfermedad emocional
- □ Drogadicción y alcoholismo fenilcetonuria

Cómo llenar el formulario:

- La Parte B de este formulario debe ser completada por un médico matriculado (MD o DO), asistente médico (physician's assistant, PA) o practicante avanzado en enfermería matriculado (advanced practice nurse, APN with prescriptive authority, RXN).
- Las Partes A y C de este formulario también deben completarse antes de que la escuela pueda hacer modificaciones en las comidas.
- Las modificaciones en las comidas continuarán hasta que un médico matriculado, asistente médico o practicante avanzado en enfermería matriculado indique que se cambien o se suspendan las modificaciones en el Formulario DS-3, que está disponible en la escuela.
- Se recomienda que un médico matriculado, asistente médico o practicante avanzado en enfermería matriculado actualice anualmente la orden de dieta indicada.

Parte A. Información del estudiante, del padre, la madre o el tutor y de la persona de contacto de la escuela – Debe estar completado por el padre, la madre o el tutor, o la persona de contacto de la escuela

1. Nombre del estudiante:	2. Fecha de nacimiento:	3. Escuela:
4. Nombre del padre, la madre o el tutor:	5. Teléfono del padre, la madre o el tutor:	
6. Nombre de la persona de contacto de la escuela:	7. Teléfono de la persona de contacto de la escuela:	

Parte B. Pedido de dieta indicada – Esta parte debe estar completada por un médico matriculado, asistente médico o practicante avanzado en enfermería matriculado tal como se especifica más arriba.

1. Especifique la discapacidad, la alergia/intolerancia alimentaria o la afección médica y explique por qué la discapacidad restringe la dieta del niño.
2. ¿Qué actividad importante de la vida se ve afectada por la discapacidad de este estudiante? Ejemplo: la alergia al maní afecta la capacidad de respirar.
3. Tipo de dieta especial: ☐ Marque si no corresponde O especifique el tipo de dieta especial (p. ej., baja en sodio, libre de gluten, para diabéticos, etc.).

4. Textura modificada:	☐ No corresponde	☐ Picada	☐ Molida	☐ Pisada
5. Líquidos modificados en su espesor:	☐ No corresponde	☐ Néctar	☐ Miel	☐ Consistencia para comer con cuchara o consistencia budín de

6. Equipos especiales de alimentació ☐ Marque si no corresponde O enumere los equipos especiales de alimentación (p. ej., una largo, un vaso con tapa para sorber, etc.).
7. Alimentos que deben eliminarse o sustituirse: Enumere aquellos alimentos específicos que deben eliminarse o sustituirse. Si se necesita más es una hoja de papel adicional.

Eliminar los siguientes alimentos:	Sustituir los siguientes alimentos:

8. Información del médico matriculado/ asistente médico/ practicante avanzado en enfermería matriculad		
Firma:	Cargo:	
Nombre en letra de imprenta:	Teléfono:	Fecha:

Parte C. Permiso del padre, la madre o el tutor – Debe estar completada por el padre, la madre o el tutor
Autorizo a que el personal de la escuela encargado de la aplicación de la dieta indicada para mi hijo converse sobre las adaptaciones especiales de la dieta de mi hijo con el personal escolar adecuado. También autorizo al médico matriculado, asistente médico o practicante avanzado en enfermería matriculado de mi hijo a aclarar aun más el pedido de dieta indicada en este formulario si así se lo solicitara el personal escolar. Firma del padre, la madre o el tutor: Fecha:

Declaración de No-discriminación del USDA – Español

De acuerdo con la ley Federal de derechos civiles y los reglamentos y políticas del Departamento de Agricultura de los E.E.U.U. (USDA), el USDA, sus agencias, oficinas y empleados e instituciones que participan en, o administran los programas del USDA, tienen prohibido la discriminación con base en raza, color, origen nacional, sexo, discapacidad, edad, o represalias o venganza por actividades previas de derechos civiles en cualquier programa o actividad conducida o financiada por el USDA. Las personas con discapacidades que requieran medios alternos de comunicación para el programa de información (por ejemplo en Braille, letra grande, audio grabado, Lenguaje de Señas, etc.), deben contactar a la Agencia (Estatal o local) donde solicitaron sus beneficios. Los individuos que sean sordos, que tengan dificultad para oír o impedimentos del habla pueden contactar al USDA mediante el Servicio Federal de 'Relay' al (800) 877-8339. Además, la información del programa puede estar disponible en otros idiomas además del inglés.
Para emitir una queja por discriminación del programa, llene un Formulario de Quejas de Discriminación del Programa del USDA, (AD-3027) que se encuentra en línea: http://www.ascr.usda.gov/complaint_filing_cust.html, y en cualquier oficina del USDA, o envíe una carta por escrito dirigida al USDA y proporcione toda la información requerida en el formulario. Para pedir una copia del formulario de quejas, llame al (866) 632-9992.
Mande su formulario completo o carta al USDA por: correo: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; o correo electrónico al: program.intake@usda.gov. Esta institución es un proveedor de oportunidades equitativas.

Discontinuation of School Meal Modifications
Prescribed by a Licensed Physician or Medical Authority (SD-3)

Licensed Physician/Medical Authority's Name ________________________________

Student's Name ____

School ____

I certify that the student named above is no longer in need of the previously prescribed meal modifications effective on the following date: ____

______________________________________	___________________________
Signature of Licensed Physician/Medical Authority	Licensed Physician/Medical Authority's Title
______________________________________	___________________________
Street Address	Date
______________________________________	___________________________
City, State, Zip	Phone

Suspensión de modificaciones en comidas escolares
indicadas por un médico matriculado o una autoridad médica (SD-3)

Nombre del médico matriculado o la autoridad médica ______________________________

Nombre del estudiante ____

Escuela ____

Certifico que el estudiante antes mencionado ya no necesita las modificaciones en las comidas indicadas anteriormente a partir de la siguiente fecha: _____________________________________

______________________________________	___________________________
Firma del médico matriculado/autoridad médica	Cargo del médico matriculado/autoridad médica
______________________________________	___________________________
Dirección	Fecha
______________________________________	___________________________
Ciudad, estado, código postal	Teléfono