California Department of Education
Nutrition Services Division
Child Nutrition Programs
CNP-925 (Rev. 06/12)

LODI UNIFIED SCHOOL DISTRICT
FOOD SERVICE DEPARTMENT

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. District Name	2. School Site Name	3. Site Telephone Number
4. Name of Participant	5. Student ID Number	6. Date of Birth
7. Name of Parent or Guardian		8. Telephone Number

9. 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.**

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

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

12. Diet prescription and/or accommodation:(*please describe in detail to ensure proper implementation-use extra pages as needed*)

13. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Foods to be omitted and substitutions: (*please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Suggested Substitutions

15. Adaptive Equipment:

16. Signature of Preparer*	17. Printed Name	18. Telephone Number	19. Date
20. Signature of Medical Authority*	21. Printed Name	22. Telephone Number	23. 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.**

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

FOR LUSD FOOD SERVICE STAFF USE ONLY:

RD Review: Y N Date:_____ Initials:_____ **Copy to student file ☐ Copy to Café Mgr ☐**

FSD Action:_____ Follow Up Action: _____

_____ _____

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INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Student ID Number:** Print the Student ID Number of the child to whom the information pertains.
6. **Date of Birth of Participant:** Print the age of the participant. For infants, please use Date of Birth.
7. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
8. **Telephone Number:** Print the telephone number of parent or guardian.
9. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
10. **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.)
11. **If Participant 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. For example: "Allergy to peanuts causes a life-threatening reaction."
12. **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. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
13. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
14. A. **Foods to Be Omitted:** List specific foods that must be omitted. For example, "exclude fluid milk."
    B. **Suggested Substitutions:** List specific foods to include in the diet. For example, "calcium fortified juice."
15. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a 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 Number:** Telephone number of person completing form.
19. **Date:** Date preparer signed form.
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 Number:** Telephone number of medical authority.
23. **Date:** Date medical authority signed form.

DEFINITIONS*:

"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 an 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, including 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.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)