

Medical Statement to Request Special Meals, Accommodations, Milk Substitutions

A licensed medical authority is defined as an individual who has the authority to write a medical prescription. In Utah, this includes:

- Medical Doctor (MD)
- Physician's Assistant (PA)
- Osteopathic Physicians (DO)
- Advance practice Registered Nurses (APRN)
- Naturopathic Physicians (ND or NMD)

Who can complete this form?	
For substitutions due to a disability <ul style="list-style-type: none"> The accommodation request must be followed by the institution. 	For substitutions NOT due to a disability <ul style="list-style-type: none"> The school/sponsor may choose to accommodate the request or not.
Licensed medical authority (see above)	Licensed medical authority (see above) Registered Nurse (RN) Registered Dietitian (RD/RDN) Parent or Guardian (Must meet meal pattern to be claimed)

Definition of Disability

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) 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-(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, genitor-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-functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Major Bodily Functions- functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions

Record of Impairment-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. Individuals who take mitigating measures to improve or control any of the conditions recognized as a disability, are still considered to have a disability and require an accommodation.

USDA Guidelines for Accommodating Special Dietary Needs

Disability-Institutions and agencies participating in federal nutrition programs **must** comply with requests for special dietary meals and any adaptive equipment with a documented disability and completed request form.

Non-disability-Institutions and agencies participating in federal nutrition programs **may** comply with requests for non-disabling medical conditions. Accommodations will be made on a case-by-case basis. However, if accommodations are made for a specific medical condition, complete requests for the same medical condition for other participants must be accommodated.

Fluid Milk Substitutions-Fluid milk substitutions apply to non-disability requests. Institutions and agencies participating in the federal nutrition program **may** accommodate complete requests with a USDA approved non-milk equivalent. If accommodations are made for one child requesting a fluid milk substitute, accommodations must be made for all children requesting a fluid milk substitute.

School/sponsor internal use only
<input type="checkbox"/> Marked as disability or treating as disability (required to accommodate request)
<input type="checkbox"/> Not marked as disability
<input type="checkbox"/> School/sponsor is accommodating request
<input type="checkbox"/> School/sponsor is not accommodating request
Signature/Date:

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1. Site Name (School/Sponsor):	2. Name of Child *	3. Age or Grade	
4. Name of Parent or Guardian		5. Telephone Number	
6. State the medical condition requiring accommodation:			
<i>This section must be completed by a licensed medical authority. Refer to the reverse side of this page for definitions.</i>			
7. Does the medical condition affect major life activities or major bodily functions? Select one of the following. *			
<input type="checkbox"/> Yes, this condition affects major life activities or major bodily functions and qualifies as a disability <input type="checkbox"/> No, this condition does not affect major life activities or major bodily functions and does not qualify as a disability			
<i>According to the ADA the term 'disability' means, with regards to an individual: a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment. The USDA has adopted this definition of a disability in child nutrition programs.</i>			
8. Provide a brief description of the major life activity or bodily function affected by the disability. *			
Consuming foods to be omitted may result in: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Rash <input type="checkbox"/> Wheezing/Coughing <input type="checkbox"/> Choking <input type="checkbox"/> Other:			
9. Describe diet prescription and/or accommodation. Must include specific foods to be omitted and substituted. *			
Foods and/or beverages to be omitted: *		Foods and/or beverages to be substituted: *	
10. Modified texture (if applicable): <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Puree			
11. Adaptive Equipment Needed (if applicable):			
12. Signature of Medical Authority & Credentials*	13. Printed Name*	14. Telephone Number	15. Date*
I give permission for the institution's personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate institution staff and to follow the prescribed diet order for my child's meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by institution personnel.			
Signature of parent or guardian:		Date:	

***Required**