PARENT INFORMATION

Special Nutrition Needs

Watervliet's School Nutrition Department makes changes for students with a documented disability such as: food anaphylaxis (severe food allergy), celiac disease, diabetes and cerebral palsy as directed by a Recognized Medical Authority. For other medical, dietary or special needs and requests, the School Nutrition Program may be able to make changes on a case-by–case basis.

Disabilities and Special Nutrition Needs

The law describes a disability as "A person with a disability is a person who has a physical or mental impairment which substantially limits one or more major life activities, and has a record of such impairment" (USDA Food and Nutrition Service, 2001).

A signed physician statement is required to be on file with the School Nutrition Program before making any disability-based change to a student's meal. **This medical statement must be updated with the School Nutrition Program whenever there is a change in your child's restrictions.** These documented changes are made at no extra cost to students.

Each special nutrition need request must be supported by a statement, signed by a recognized medical authority, which explains the food substitution that is requested.

The medical statement must include:

- an identification of the medical or other special dietary condition which restricts the child's diet
- the food or foods to be omitted from the child's diet
- the food or choice of foods to be substituted

A recognized medical Authority is defined as:

- Physician
- Physician Assistant
- Nurse Practitioner
- Other professionals specified by the state Agency

For a copy of the Medical Statement to Request Special Meal Accommodations, please visit our Nutrition Services Web page www.watervlietps.org or call 269-463-0799 for a copy.

Other Medical or Dietary Reasons for Special Nutrition Needs

Watervliet School Nutrition may make modifications to a student's meal with a signed physician statement for children without disabilities such as: lactose intolerance, gluten intolerance or weight control. The School Nutrition Program makes reasonable changes at no extra cost to students.

Other personal preference for Special Nutrition Needs

Other personal requests made in writing to the School Nutrition Program will be considered on a case-by-case basis. Request such as: vegetarian or "food dislikes" will be considered while adhering to USDA guidelines. As children grow their tastes change and should be encouraged to try foods that are new or prepared differently than they are accustomed to.

For questions about your student's special nutrition needs; please call June Altom, Director of Food & Nutrition at 269-463-0799.

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Michigan Department of Education
Office of School Support Services

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

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

1. School/Agency Name:	2. Site Name:	3. School/Center Telephone:
4. Name of Participant/Student:		5. Age or Date of Birth:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions 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. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA),** or **nurse practitioner (NP).**

☐ 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 (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), or speech pathologist must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the nutrient standards for non-dairy beverages offered as milk substitutes. 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, registered dietitian, nurse practitioner, parent, or guardian may sign this form.**

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

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

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

12. 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. Food(s) To Be Omitted:	B. Suggested Substitution(s)

13. Indicate Texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Adaptive Equipment:

15. Signature of Preparer:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority:	20. Printed Name: (include credentials)	21. Telephone	22. Date

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Michigan Department of Education
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REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS 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, family day care home, etc.)
3. **Site Telephone:** 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. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check (☐) a box to indicate whether participant has a disability or does not have a disability.
9. **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.)
10. **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."
11. **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."
12. 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, "Nutritionally equivalent nondairy beverage."
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. **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.)
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority. Include credentials.
21. **Telephone:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

The American with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. (For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008). Information regarding the ADAAA, which expanded the definition of disability, can be found at: http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf

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