

## MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. Program/Provider Name	2. Program/Provider Address	3. Program Telephone Number											
4. Name of Child Participant		5. Age or Date of Birth											
6. Name of Parent or Guardian		7. Telephone Number											
<p><b>8. Check One:</b></p> <p><input type="checkbox"/> Child has a disability or a medical condition that <b>requires</b> a special meal and/or accommodation. (Refer to definitions on reverse side of this form.) Sites participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment.</p> <p><input type="checkbox"/> Child does not have a disability but is requesting a special meal or accommodation due to a food intolerance or other medical reason. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests.</p> <p><b>A licensed physician, physician assistant, or a nurse practitioner must complete and sign this form.</b></p>													
9. The child's disability or medical condition requiring a special meal or accommodation:													
10. If child has a disability, provide a brief description of his/her 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):													
<p><b>12. Indicate food texture for above participant:</b></p> <p style="text-align: center;"> <input type="checkbox"/> Regular                  <input type="checkbox"/> Chopped                  <input type="checkbox"/> Ground                  <input type="checkbox"/> Pureed         </p>													
<p><b>13. 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):</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center; border: none;"><b>A. Foods To Be Omitted</b></td> <td style="width: 50%; text-align: center; border: none;"><b>B. Suggested Substitutions</b></td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>				<b>A. Foods To Be Omitted</b>	<b>B. Suggested Substitutions</b>	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____												
_____	_____												
_____	_____												
_____	_____												
14. Adaptive equipment to be used:													
15. Signature of Recognized Medical Authority*	16. Printed Name	17. Telephone Number	18. Date										

**\*For this purpose, a recognized medical authority in Georgia is a licensed physician, physician assistant, or a nurse practitioner.**

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

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## INSTRUCTIONS

1. **Program/Provider:** Print the name of the site where meals will be served (e.g., school site, child care center, etc.).
2. **Program/Provider Address:** Print the name of the site's address.
3. **Program Telephone Number:** Print the telephone number of site where meal will be served.
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 Number:** 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 (e.g., 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 the recognized medical authority.
12. **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".
13. **A. Foods to Be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).  
**B. Suggested Substitutions:** List specific foods to include in the diet (e.g., calcium-fortified juice).
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
15. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
16. **Printed Name:** Print name of medical authority.
17. **Telephone Number:** Telephone number of medical authority.
18. **Date:** Date medical authority signed form.

### **Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:**

**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; 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.

**Major bodily functions** have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

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