MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

Please complete this form and return the ORIGINAL to the Nutrition Services office at 2075 W Acacia Ave, Hemet, CA 92545 or FAX to 951-658-3182

1. District Name	2. School Name	3. School Telephone Number
Hemet Unified School District		

4. Student Name	5. Permanent Student ID #	6. Date of Birth	7. Grade

8. Name of Parent or Guardian	9. Telephone Number	10. Meals Needed
		☐Breakfast ☐Lunch ☐Snack

11. 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.

☐ 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 recognized medical authority (licensed physician, physician assistant, or nurse practitioner) must complete and sign this form.

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

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

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

15. Indicate any texture modifications required:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

16. Is the condition life threatening:

☐ Yes ☐ No

17. Check all applicable omissions OR attach a copy of special diet:

Dairy: ☐Fluid Milk ☐All Dairy Products Containing Lactose ☐All Foods with Dairy Protein (Casein/Whey)
Egg: ☐Whole Eggs ☐Egg Yolk ☐Egg White ☐All Foods Containing Egg
Wheat/Grains: ☐All Wheat Products ☐All Gluten Containing Products (Wheat, Oats, Rye, Barley)
Corn: ☐Whole Corn ☐All Corn Containing Products
Nuts: ☐Peanuts ☐Tree Nuts (Walnuts, Almonds) ☐Seeds (Sesame, Sunflower)
Soy: ☐Soy Beans (Edamame) ☐All Soy Ingredients
Fish: ☐All Fish ☐Shellfish
Fruit/Juices: ☐Citrus ☐Fruit ☐Strawberries ☐Other:
Other: (if applicable):____

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Suggested Substitutions: (Please Note: Juice is only an acceptable substitute for fluid milk if the recognized medical authority documents a disability on #11 of this form and *requires* juice to be substituted for milk.)

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18. Indicate Adaptive Equipment (if required):

19. Signature of Recognized Medical Authority*	20. Printed Name	21. Telephone Number	22. Date

*** For this purpose, a recognized medical authority in California is a licensed physician, physician assistant, or nurse practitioner. The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.**

District Use ONLY:
(Initial & date to confirm receipt) Nutrition Specialist ______________ Credentialed School Nurse ______________

Revised-10/28/2016

INSTRUCTIONS

1. **School/Agency:** Hemet USD prefilled, nothing more required.
2. **School:** Print the name of the school where meals will be served.
3. **School Telephone Number:** Print the telephone number of school where meal will be served.
4. **Name of Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Student ID:** Print student's permanent identification number.
6. **Date of Birth:** Print the date of birth of the student.
7. **Grade:** Print grade of student.
8. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
9. **Telephone Number:** Print the telephone number of parent or guardian.
10. **Meals Needed:** Please check (✓) the meals that the student will eat at school on a daily basis.
11. **Check One:** Check (✓) a box to indicate whether student has a disability or does not have a disability.
12. **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.).
13. **If Student 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).
14. **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 (e.g., All foods must be either in liquid or pureed form. Participant cannot consume any solid foods).
15. **Indicate any Texture Modifications Required:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
16. **Is the condition life threatening:** Check (✓) yes or no.
17. **A. Foods to Be Omitted:** List or check (✓) specific foods that must be omitted.
    B. Suggested Substitutions: List specific foods to include in the diet.
18. **Indicate Adaptive Equipment if Required:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **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 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.

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