## Medical Statement to Request Special Meals, Accommodations, Milk Substitutions

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	1. Site Name (School/Sponsor):	2. Name of I	Parent/Guardian	3. Email Address	
This section must be completed by a licensed medical authority. Refer to the reverse side of this page for definitions.         8. Provide a brief description of the major life activities or bodily functions affected by the condition. *         Consuming foods to be omitted may result in:         Nausea       Vomiting         Diarrhea       Itching         Swelling       Rash         Other:       Wheezing/Coughing         9. Describe diet prescription and/or accommodation. Must include specific foods to be excluded and substituted. *         Foods and/or beverages to be excluded: *       Foods and/or beverages to be substituted: *         10. Modified texture (if applicable):       Chopped       Ground       Puree         11. Adaptive Equipment Needed (if applicable):       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 medical authority to further clarify the prescribed diet order on this form if requested to do so by institution personnel.	4. Name of Child *	5. Date of Birth		6. Telephone Number	
8. Provide a brief description of the major life activities or bodily functions affected by the condition. *   Consuming foods to be omitted may result in:   Nausea   Nausea   Other:   9. Describe diet prescription and/or accommodation. Must include specific foods to be excluded and substituted. *   Foods and/or beverages to be excluded: *   In Modified texture (if applicable):   Competed   Ground   Puree   Provide texture (if applicable):   Provide texture (if applicable): Provide	7. State the medical condition requiring acc	ommodation.			
Consuming foods to be omitted may result in:	This section must be completed by a license	d medical authorit <u>y</u> . I	Refer to the reverse sid	de of this page for definitions.	
Nausea Vomiting   Diarrhea Itching   Swelling Rash   Wheezing/Coughing   Other: <b>9. Describe diet prescription and/or accommodation. Must include specific foods to be excluded and substituted.*</b> Foods and/or beverages to be excluded:* Foods and/or beverages to be excluded:* Foods and/or beverages to be excluded:* Foods and/or beverages to be substituted: * Interview of the substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Interview of the substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be substituted: * Interview of the substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be exclu	8. Provide a brief description of the major	life activities or bodi	ly functions affected	by the condition. *	
Nausea Vomiting   Diarrhea Itching   Swelling Rash   Wheezing/Coughing   Other: <b>9. Describe diet prescription and/or accommodation. Must include specific foods to be excluded and substituted.*</b> Foods and/or beverages to be excluded:* Foods and/or beverages to be excluded:* Foods and/or beverages to be excluded:* Foods and/or beverages to be substituted: * Interview of the substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Interview of the substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be substituted: * Interview of the substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be excluded: * Foods and/or beverages to be substituted: * Foods and/or beverages to be excluded: * Foods and/or beverages to be exclu					
Other:   9. Describe diet prescription and/or accommodation. Must include specific foods to be excluded and substituted. *   Foods and/or beverages to be excluded: *   Foods and/or beverages to be substituted: *   10. Modified texture (if applicable):    11. Adaptive Equipment Needed (if applicable):   12. Signature of Medical Authority & Credentials*   13. Printed Name*   14. Telephone Number   15. Date*         In give permission for the institution's personnel responsible for implementing my child's prescribed diet order to discuss my child's meals. I also give permission for the institution's personnel responsible for implementing my child's 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.	Consuming foods to be omitted may resu	lt in:			
9. Describe diet prescription and/or accommodation. Must include specific foods to be excluded and substituted. *         Foods and/or beverages to be excluded: *         Foods and/or beverages to be excluded: *         Foods and/or beverages to be excluded: *         Foods and/or beverages to be substituted: *         In Modified texture (if applicable): Chopped Ground 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 medical authority to further clarify the prescribed diet order on this form if requested to do so by institution personnel.		☐Itching ☐ Swel	ling 🔲 Rash 🔲 W	heezing/Coughing	
Foods and/or beverages to be excluded: *       Foods and/or beverages to be substituted: *         10. Modified texture (if applicable): □       Chopped □       Ground □       Puree         11. Adaptive Equipment Needed (if applicable):       Ground □       Puree         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.	□ Other:				
Foods and/or beverages to be excluded: *       Foods and/or beverages to be substituted: *         10. Modified texture (if applicable): □       Chopped □       Ground □       Puree         11. Adaptive Equipment Needed (if applicable):       Ground □       Puree         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.	0 Describe dist procerintian and/or accom	modation Musting	uda spacific faads ta	he evaluated and substituted *	
10. Modified texture (if applicable):       Chopped       Ground       Puree         11. Adaptive Equipment Needed (if applicable):       It. Adaptive Equipment Needed (if applicable):       It. Signature of Medical Authority & Credentials*       It. Printed Name*       It. Telephone Number       It. 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.	9. Describe diet prescription and/or accom	modation. Wust incl	ude specific foods to	be excluded and substituted. *	
10. Modified texture (if applicable):       Chopped       Ground       Puree         11. Adaptive Equipment Needed (if applicable):       It. Telephone Number       15. Date*         12. Signature of Medical Authority & Credentials*       13. Printed Name*       It. 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.	Foods and/or heverages to be	avcludad: *	Foods a	nd/or haverages to be substitu	tod. *
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.					
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.	10. Modified texture (if applicable):  Cho	opped 🔲 Ground	Puree		
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.	11. Adaptive Equipment Needed (if applical	ble):			
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.	12. Signature of Medical Authority & Crede	redentials* 13. Printed Name*		14. Telephone Number	15. Date*
Signature of parent or guardian: Date:	special dietary accommodations with any ap I also give permission for my child's medical	propriate institution	staff and to follow the	e prescribed diet order for my c	hild's meals.
	Signature of parent or guardian:			Date:	

\* **Required** Child Nutrition Programs This institution is an equal opportunity provider.

## 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)

## USDA Guidelines for Accommodating Special Dietary Needs

Institutions and agencies participating in federal nutrition programs <u>must</u> comply with requests for special dietary meals and any adaptive equipment with a documented disability and completed request form.

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.

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

**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.

**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.