MEDICAL STATEMENT TO REQUEST
CHILD NUTRITION PROGRAMS
SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name: Yours for Children, Inc. 1-800-222-2731 yfci@yoursforchildren.com	2. Provider Name and YFCI #	3. Provider Telephone Number
4. Name of Participant/Child		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Telephone Number

8. 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. **A State licensed health care professional who is authorized to write medical prescriptions under State law must sign this form.**

☐ 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 State licensed health care professional, physician's assistant, or nurse practitioner 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 State licensed health care professional, physician's assistant, 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. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

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*)

A. Foods To Be Omitted	B. Suggested Substitutions

14. Adaptive Equipment:

15. Signature of Preparer*	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority*	20. Printed Name	21. Telephone Number	22. Date

*** A State licensed health care professional who is authorized to write medical prescriptions under State law is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.**

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

This institution is an equal opportunity provider.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS
CHILD NUTRITION PROGRAMS

INSTRUCTIONS

Note: According to 7 CFR, part 226.20 and FNS Instruction 783-2, Rev.1, food substitutions for medical reasons can be made only when there is a written statement from a medical authority. This written statement must include the medical reason and recommended alternate foods.

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, community center, etc.)
3. **Site Telephone Number:** Print 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 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 is affected by the 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. **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. For example, "exclude peanut butter."
    B. Suggested Substitutions: List specific foods to include in the diet. For example, "sunflower seed spread."
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 Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of a State licensed health care professional who is authorized to write medical prescriptions under State law.*
20. **Printed Name:** Print name of State licensed health care professional.
21. **Telephone Number:** 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

This institution is an equal opportunity provider.