2016

Idaho State Department of Education
Child Nutrition Programs

MEDICAL STATEMENT:

Request for Special Meals and/or Accommodations

(1) Name of Participant	(2) Age or DOB	(3) Sponsor	(4) Site
(5) Name of Parent /Guardian, or Auth. Rep.	(6) Telephone (Parent /Guardian, or Auth. Rep.) ( )		(7) Site Telephone Number ( )

(8) Must check one:

☐ Participant is disabled or has a medical condition and *requires* a special meal or accommodation. (Refer to definition on reverse side of this form.) Sponsors must comply with requests for special meals and any adaptive equipment. **A licensed physician, physician assistant, nurse practitioner, or dentist must sign this form.**

☐ Participant is not disabled, but is *requesting* a special meal or accommodation. An example may include food intolerances, and is not intended to include food preferences. Sponsors are encouraged to accommodate reasonable requests. **A licensed physician, physician assistant, nurse practitioner, registered dietitian, or registered nurse must sign this form.**

(9) Disability or medical condition requiring a special meal or accommodation: _____

_____

(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability:

_____

_____

(11) Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation) _____

_____

(12) Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Foods to be omitted and substitutions: Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

(13) Foods to be omitted	(14) Suggested substitutions
_____	_____
_____	_____
_____	_____
_____	_____

(15) Adaptive Equipment: _____

(16) Signature of Preparer*	(17) Printed Name	(18) Telephone ( )	(19) Date
(20) Signature of Medical Authority*	(21) Printed Name	(22) Telephone ( )	(23) Date
(24) Signature of Parent/Guardian	(25) Printed Name	(26) Telephone ( )	(27) Date

** Participants with a disability require a signature from a physician, physician assistant, nurse practitioner, or dentist. For non-disabled participants, a licensed physician, physician assistant, nurse practitioner, registered dietitian or registered nurse must sign the form.*

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