Michigan Department of Education
Office of School Support Services

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. School/Agency Name:	2. Site Name:	3. Site Telephone:
4. Name of Participant/Student:		5. Participant Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐Participant has a disability or a medical condition and *requires* a special meal or accommodation (Refer to instructions 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. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP).**

☐Participant does not have a disability, but is requesting a special meal or accommodation due to religious, cultural, economic, or other preferences. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests, but are not required to do so. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), speech pathologist, or parent/guardian must sign this form.**

☐Participant *does not have a disability*, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), or parent/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. Specific 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; see reverse side.*)

A. Food(s) To Be Omitted: **B. Suggested Substitution(s)**

_____

_____

13. Indicate Texture:

☐Regular ☐Chopped ☐Ground ☐Pureed

14. Adaptive Equipment Needed (if applicable):

15. Signature of Preparer:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority:	20. Printed Name: (include credentials and license/ registration number)	21. Telephone	22. Date

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REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Agency Name:** Print the name of the school or agency that is providing the form to the parent.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ school, XYZ child care center, XYZ family day care home, etc.).
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Parent/Guardian Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check a box to indicate whether participant has a disability and is requesting accommodation, or does not have a disability, but is requesting special accommodation and/or fluid milk substitution.
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 the physical or medical condition affects the participant. 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. **Specific food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted and what must be offered in their place. For example, *Foods to be Omitted: "peanut butter" or "any food containing gluten"* and *Foods to Be Substituted: "peanut-free soy butter or sunflower butter" or "gluten-free alternative. If a similar product to what is on menu is not available without gluten, provide a reasonable substitute that does not contain gluten."*
13. **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."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include: sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
15. **Signature of Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
16. **Printed Name:** Print name of parent/guardian completing form.
17. **Date:** Date parent/guardian signed form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
19. **Printed Name with Credentials:** Print name of medical authority, including credentials.
20. **Telephone:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

Disability Definition: The Americans 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). More Information regarding the ADAAA, which expanded the definition of disability, see the Comparison of ADA and ADAAA sheet (http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf).

USDA Nondiscrimination Statement: In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, and reprisal or retaliation for prior civil rights activity. (Not all prohibited bases apply to all programs.)

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible State or local Agency that administers the program or USDA's TARGET Center at **(202) 720-2600** (voice and TTY) or contact USDA through the Federal Relay Service at **(800) 877-8339**. Additionally, program information is available in languages other than English.

To file a complaint alleging discrimination, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at **http://www.ascr.usda.gov/complaint_filing_cust.html**, or at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call **(866) 632-9992**. Submit your completed form or letter to USDA by:

mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

fax:
(202) 690-7442; or
email:
program.intake@usda.gov

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