REQUEST FOR SPECIAL MEAL ACCOMMODATION DUE TO MEDICAL CONDITION:

A licensed physician, physician assistant, nurse practitioner, or dentist must sign this form (line 15)

(1) Name of Student/Participant	(2) Age or D.O.B.	(3) District/Organization	(4) School/Site

(5) Name of Parent /Guardian, or Auth. Rep.	(6) Telephone (Parent /Guardian, or Auth. Rep.) ( )	(7) School/Site Telephone ( )

(8) Definitions

It was determined that the Student/Participant has a medical condition or is disabled and requires a special meal or accommodation to accommodate the following criteria:

The Americans with Disabilities Act (ADA) Amendments Act of 2008 made important changes to the meaning and interpretation of the term "disability." The changes demonstrated Congress's intent to restore the broad scope of the ADA by making it easier for an individual to establish that he or she has a disability. After the passage of the ADA Amendments Act, **most physical and mental impairments constitute a disability**. Therefore, rather than focusing on whether or not a participant has a disability, sponsors focus on working collaboratively with parents, guardians or participants to ensure an equal opportunity to participate in the Child Nutrition Programs and receive program benefits.

"Disabled person" *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 (1) 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; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.*

"**Major life activities**" *are broadly defined and 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 life activities" also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (See 29 USC § 705(9) (b) and 42 USC § 12101.)*

(9) Provide a brief description of student/participant's physical or mental impairment that substantially limits one or more major life activity:

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

(11) Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed ☐ Liquid or Other: _____

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.

(12) Foods to be Omitted	(13) Suggested Substitutions

(14) Adaptive Equipment: _____

(15) Signature of Medical Authority	(16) Medical Authority Printed Name	(17) Telephone ( )	(18) Date

(19) Signature of Parent/Guardian	(20) Printed Name	(21) Telephone ( )	(22) Date

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

INSTRUCTIONS: Fill in the fields with the following information

1) Name of student/participant: Individual who will receive the meal.
2) Age of student/participant: For infants, please use D.O.B. (Date of Birth).
3) District/Organization: Name of the organization where Child Nutrition Program meals will be served.
4) School/Site: Location where meal will be served (e.g., school site, child care center, community center, RCCI).
5) Name of student/participant's parent, guardian, or authorized representative (i.e. individual responsible for the care of student/participant in CNP program).
6) Telephone: Telephone number of guardian, parent, or authorized representative.
7) School/Site Telephone: Telephone number of site where meal will be served. See #4.
8) Definitions for accommodating meal requirements and definitions.
9) Provide a brief description of student/participant's physical or mental impairment that substantially limits one or more major life activity: Describe how condition affects eating. For example: "Allergy to peanuts causes anaphylactic shock which causes trouble breathing, choking, and potential death unless epinephrine injection is given immediately to the child and the child is sent to the emergency room for follow-up treatment".
10) Diet Prescription and/or accommodation: Describe specific diet or accommodation that has been prescribed by a physician. For example, "All foods must be either in liquid or pureed form. Child cannot consume any solid foods".
11) Indicate Texture: Check the type of texture of food that is required. If the participant does not need any modification check "regular". The "other" category might be used to specify when various liquid consistencies are prescribed (i.e. thin, nectar, honey, pudding).
12) Foods that need to be omitted: List specific foods that need to be omitted. For example, "exclusion of fluid milk".
13) Suggested Substitutes: List specific foods to include in the diet. For example, "lactose reduced milk, soy milk".
14) Adaptive Equipment: Describe specific equipment required to feed the participant. (Examples may include tippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
15) Signature of medical authority: Signature of medical authority requesting the special meal or accommodation.
16) Printed Name: Print name of medical authority.
17) Telephone: Telephone number of medical authority.
18) Date: Indicate when form was completed.
19) Signature of parent/guardian.
20) Printed Name: Print name of parent/guardian.
21) Telephone: Telephone number of parent/guardian.
22) Date: Indicate when form was completed.

ALTERNATE REQUEST FOR MEAL PREFERENCE:

(1) Name of Student/Participant	**(2) Age or D.O.B.**	**(3) District/Organization**	**(4) School/Site**
(5) Name of Parent /Guardian, or Auth. Rep.	**(6) Phone # (Parent /Guardian, or Auth. Rep.)** ( )		**(7) Alternate Telephone** ( )

(8) Participant is not disabled, but is *requesting* a substitution for food preference(s). An example may include a vegetarian and vegan diets, which constitute food *preferences*. Please list specific foods to be omitted and suggest substitutions. You may use an attached sheet with additional information.

(9) Foods to be omitted	**(10) Suggested substitutions**

(11) Signature of Parent/Guardian	**(12) Printed Name**	**(13) Parent Phone Number** ( )	**(14) Date**

Districts are encouraged, but not required, to accommodate meal preference requests. No medical authority signature required for meal preferences.