

# MEDICAL STATEMENT FOR STUDENTS REQUIRING SPECIAL MEALS

for a Student WITH a Disability

This Special Medical Statement is **ONLY** for a participant with a disability that affects their diet. This form must be:

- \* Thoroughly completed and signed by a licensed physician
- \* Submitted to the school before any meal modifications will be made in the United States  
Department of Agriculture Child Nutrition Programs
- \* Updated whenever the participant's diagnosis or special diet changes

## PART 1: STUDENT INFORMATION

Parent or Guardian must complete - Please PRINT

Student's Name Last / First / Middle Initial		Date of Birth
Parent / Guardian's Name	Home Phone	Work Phone
Parent/Guardian Address	City	State Zip Code

Name of School Attending:

**Release of Information Clause:** Your signature allows the school district to share information on a "need to know" basis with employees of the district in order to accommodate other school-related activities involving food.

Parent/Guardian Signature	Date
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Note to Parent/Guardian: You may authorize the Manager/Director of the school lunch program to clarify this Medical Statement **with the Physician** by signing the Voluntary Authorization section at the end of this form.

## PART 2: DIET ORDER (Physician's supporting information)

A Licensed physician must complete this portion. PLEASE PRINT.

\_\_\_\_\_ The student named above has a disability and requires a special diet or food accomodation  
Yes

*An individual with a disability is described under Section 504 of the rehabilitation Act (1973) and the Americans with Disability Act (ADA) as a person who has a physical or mental impairment that substanstially limits one or more "major life activities," has a record of such impairment, or is regarded as having such an impairment. "Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.*

1. Identify the student's disability: \_\_\_\_\_ **AND / OR**
  - 1a. Identify food allergy that is life-threatening/anaphylactic (considered a disability): \_\_\_\_\_
2. List the "major life activities" affected by the disability: \_\_\_\_\_
3. Describe how the disability restricts the Student's diet: \_\_\_\_\_



## VOLUNTARY AUTHORIZATION

A parent/guardian may choose to complete this section giving permission to the licensed physician to discuss and clarify a diet order with a Food Service Director of a school.

As stipulated in FNS Instruction 783, Rev. 2, Section V Cooperation:

*"When implementing the guidelines of this instruction, food service personnel should work closely with the parent(s)/guardian(s)/student or responsible family member(s) and with all other medical and community personnel who are responsible for the health, well-being and education of a participant with a disability that accommodations are made to allow the individual's participation in the meal service."*

*This voluntary authorization encourages such cooperation by allowing the following:*

After review of this Medical Statement, the school may need more information or clarification from the physician before it can provide the special diet. By signing this authorization you are permitting the school to discuss or clarify the diet order with the physician.

Before any changes agreed to between the Food Service Director/Manager and physician take place, the parent(s)/guardian(s)/student need to be informed.

The changes agreed to will then be incorporated into an amended Medical Statement

If more information is needed but this authorization statement has not been signed, implementation of the special diet may be delayed.

If authorization is signed, make a copy of this document before submitting to the school.

This authorizes the licensed physician to discuss or clarify the diet order prescribed for:

\_\_\_\_\_  
(Student's Name)

with the Food Service Manager/Director at:

\_\_\_\_\_  
(Name of School)

This authorization may be revoked at any time by submitting a request in writing to the physician who originally signed the Medical Statement.

I understand that specific information disclosed pursuant to this authorization may be subject to re-disclosure by the school Food Service Manager/Director and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call tp;; free (866) 632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."