SJUSD NUTRITION SERVICES
MEDICAL STATEMENT TO REQUEST
SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name **San Juan Unified School District**	2. School Site Name	3. Site Telephone Number
4. Name of Student		5. Age or Date of Birth
6. Name of Parent or Guardian	7. Email Address	8. Telephone Number

9. Check One:

☐ Participant has a disability or a medical condition that **requires** a special meal and/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.

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to a food intolerance or other medical reason. 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 licensed physician, physician assistant, or a nurse practitioner must complete and sign this form.

10. Description of Student's Physical or Mental Impairment Affected:

11. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

12. Indicate food texture for above student:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. Foods to be Omitted and Appropriate Substitutions:

A. Foods To Be Omitted	B. Suggested Substitutions

14. Adaptive equipment to be used:

15. Signature of State Licensed Healthcare Professional*	16. Printed Name	17. Telephone Number	18. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, physician assistant, or a nurse practitioner.**

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

INSTRUCTIONS

2. **School Site Name:** Print the name of the school site where meals will be served.

3. **Site Telephone Number:** Print the telephone number of site where meal will be served.

4. **Name of Student:** Print the name of the student to whom the information pertains.

5. **Age or Date of Birth:** Print the age or date of birth of the student.

6. **Name of Parent or Guardian:** Print the name of the person requesting the student's medical statement.

7. **Email Address:** Print the email address of parent or guardian.

8. **Telephone Number:** Print the telephone number of parent or guardian.

9. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.

10. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child's diet.

11. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

12. **Indicate Texture:** If the participant does not need any modification, check "Regular".

13. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).

14. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

15. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

16. **Printed Name:** Print name of state licensed healthcare professional.

17. **Phone Number:** Print the telephone number of state licensed healthcare professional.

18. **Date:** Date state licensed healthcare professional signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as 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 an impairment.

Physical or mental impairment means (a) 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; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities 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 bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.