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 Participant		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. The participant's disability or medical condition requiring a special meal or accommodation:

11. If participant has a disability, provide a brief description of his/her major life activity affected by the disability:

12. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):

13. Indicate food texture for above participant:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. 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):

A. Foods To Be Omitted	B. Suggested Substitutions

15. Adaptive equipment to be used:

16. Signature of Recognized Medical Authority*	17. Printed Name	18. Telephone Number	19. Date

***For this purpose, a recognized medical authority 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

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site).
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant'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. **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.).
11. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability (e.g., Allergy to peanuts causes a life-threatening reaction).
12. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by the recognized medical authority.
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. A. **Foods to Be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    B. **Suggested Substitutions:** List specific foods to include in the diet.
15. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining.
16. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
17. **Printed Name:** Print name of medical authority.
18. **Telephone Number:** Telephone number of medical authority.
19. **Date:** Date medical authority 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.