



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

<b>1. School/Agency Name</b> <b>San Juan Unified School District</b>	<b>2. School Site Name</b>	<b>3. Site Telephone Number</b>	
<b>4. Name of Participant</b>		<b>5. Age or Date of Birth</b>	
<b>6. Name of Parent or Guardian</b>	<b>7. Email Address</b>	<b>8. Telephone Number</b>	
<b>9. Check One:</b> <input type="checkbox"/> Participant has a disability or a medical condition that <b>requires</b> 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.  <input type="checkbox"/> 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.  <b>A licensed physician, physician assistant, or a nurse practitioner must complete and sign this form.</b>			
<b>10. The participant's disability or medical condition requiring a special meal or accommodation:</b>			
<b>11. If participant has a disability, provide a brief description of his/her major life activity affected by the disability:</b>			
<b>12. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):</b>			
<b>13. Indicate food texture for above participant:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed			
<b>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):</b>			
<b>A. Foods To Be Omitted</b>		<b>B. Suggested Substitutions</b>	
<b>15. Adaptive equipment to be used:</b>			
<b>16. Signature of Recognized Medical Authority*</b>	<b>17. Printed Name</b>	<b>18. Telephone Number</b>	<b>19. Date</b>

**\*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.**

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## 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.