Alachua County Public Schools Food and Nutrition Services

Medical Statement to Request Meal Modifications and/or Accommodations

SECTION A: TO BE COMPLETED BY PARENT/GUARDIAN (Please sign at item #17 on page 2)

1. School Name	2. School Telephone Number
3. Student Name	4. Age/Date of Birth
5. Parent/Guardian Name	6. Telephone Number

7. Does your student typically eat school provided meals? □ Yes □ No

7a. If yes, which school provided meals will your child eat?

□ Breakfast □ Lunch □ Afterschool

8. Which days will your child most likely eat school provided meals?

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ N/A

9. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Family Education Rights and Privacy Act (FERPA), I herby authorize _____ to release my child's protected health information as is necessary for the specific purpose of providing special diet information to _____.

printed name of child's recognized medical authority

printed name of school district

I consent to allow the recognized medical authority to exchange information listed on this form and relevant information from my child's records with the school district as needed.

I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I also understand that I may revoke this authorization at any time, except to the extent that action has already been taken based on this authorization.

Signature of parent or guardian: _____ **Date:**_____

SECTION B: TO BE COMPLETED BY A STATE-LICENSED HEALTHCARE PROFESSIONAL

Medical Doctor (MD), Doctors of Osteopathy (DO), Physical Assistant (PA), Advanced Registered Nurse Practitioner (ARPN), or Registered Dietitian (RD) (***MUST SIGN*** **item #19 on page 2)**

10. Does the student have food allergies? □ Yes □ No

11. Does the student have other conditions that restrict the diet? If not, skip this question.

Select all that apply:

□ Celiac disease and/or gluten intolerance

□ EOE (eosinophilic esophagitis)

□ Eczema/skin issues

□ Other -Specify diagnosis: _____

12. Please check one:

□ Student has a disability or medical condition that requires a meal modification or accommodation (Refer to Page 3 for definitions). Schools and agencies participating in federal nutrition programs must comply with all such requests and provide any necessary adaptive equipment.

□ Student does not have a disability, but is requesting a meal modification or accommodation due to food intolerance(s) or other dietary concerns. Food preferences are not an appropriate basis for this request. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests.

(Section B continues on the next page)

Medical Statement to Request Meal Modifications and/or Accommodations

(Continued)

SECTION B (Continued):

13. Please select the foods to be *excluded* from the student's diet, if applicable:

Eggs:

□ Eggs-All

□ Whole-small amounts cooked in foods allowed

Wheat:

□ All wheat

□ Other (please specify): _____

Shellfish:

□ All shellfish

□ Other: _____

Fish:

□ All fish

□ Other: _____

Soy:

□ All soy

□ All soy, except soybean oil

□ Other: _____

Sesame:

□ All sesame

□ Other: _____

Milk:

□ All foods containing dairy proteins (raw or cooked) are restricted. Not due to lactose intolerance.

□ Cheese

□ Yogurt

□ Ice Cream

□ Fluid Milk (Cow's milk)

Choose a substitution for fluid milk:

□ Soy milk

□ Lactose-free milk

□ Juice/water (restricted to children with disabilities)

□ Other (restricted to children with disabilities)

Peanuts:

□ All peanuts

□ Other: _____

Tree Nuts:

□ All tree nuts

□ Other: _____

14. Other food allergies and/or intolerances to be *excluded* from the student's diet :

_____

15. Suggested substitutions/adaptive equipment/specialty utensils: (Attach specific diet/meal plan, if needed)

_____

16. Diet prescription and/or accommodation: (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods). Texture and liquid modifications should align with IDDSI(https://iddsi.org/Framework) recommendations.

FOOD: □ Regular (7) □ Easy to Chew (7) □ Soft & Bite-Sized (6) □ Minced & Moist (5) □ Pureed (4) □ Liquidized (3)

LIQUIDS: □ Thin (0) □ Slightly Thick (1) □ Mildly Thick (2) □ Moderately Thick (3) □ Extremely Thick (4)

Recommended Thickener: _____

SECTION C: SIGNATURES

17. Parent or Guardian Signature	**18. Date**
19. Medical Authority Signature	**20. Printed Name**
21. Telephone Number	**22. Date**

INTERNAL USE ONLY

Date received by School:	Date Placed in Student Health Record:	Date Copy Given to Food Service:
Recipients Signature:	Filer's Signature:	Recipients Signature:

Medical Statement to Request Meal Modifications and/or Accommodations

(Continued)

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TrY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/ default/ files/ documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) Mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
(2) Fax: (833) 256-1665 or (202) 690-7442; or
(3) Email: program.intake@usda.gov

This institution is an equal opportunity provider.

Definitions

"A Person with a disability" is defined as any person who has a physical or mental impairment that 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, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, 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, working, and major bodily functions (including, but not limited to: functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions).

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

(CITATIONS FROM SECTION 504 OF THE REHABILITATION ACT OF 1973
AND A&IERICANS WITH DISABILITIES ACT OF 1990)

Medical Statement to Request Meal Modifications and/or Accommodations

(Continued)

Instructions

SECTION A: TO BE COMPLETED BY PARENT/GUARDIAN

1. School Name: Print the name of the school that is providing the form to the parent or guardian.
2. School Telephone Number: Print the telephone number of the school.
3. Student Name: Print the name of the student to whom the information pertains
4. Age or Date of Birth: Print the age of the student. For infants, please use date of birth.
5. Parent or Guardian Name: Print the name of the person requesting the student's medical statement.
6. Telephone Number: Print the telephone number of the parent or guardian.
7. Indicate if the student typically eats school provided meals.

7a. Check One: Check (✓) a box to indicate which school provided meals will the student eat.

8. Check One: Check (✓) a box to indicate which days the student will most likely eat school provided meals.
9. Fill in the blanks of Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Family Education Rights and Privacy Act (FERPA) for protected health information.

SECTION B: TO BE COMPLETED BY A STATE-LICENSED HEALTHCARE PROFESSIONAL

10. Check One: Check (✓) a box to indicate whether the student has food allergy or does not have a food allergy.
11. Indicate if the student has medical conditions that restrict diet. Check (✓) all applicable boxes corresponding to other conditions that restrict the diet. If the student does not have other conditions that restrict the diet, skip this question.
12. Check (✓) if the student has a disability or a medical condition that requires a special meal or accommodation, or not.
13. Medical Statement to Request Meal Modifications and/or Accommodations all applicable boxes corresponding to foods to be excluded from the student's diet. If none apply, skip this question.
14. List other food allergies/intolerants to be excluded from the diet.
15. List specific substitute, equipment, etc. to include in the diet (e.g., lactose-free milk).
16. Diet Prescription and/or Accommodation: Describe a specific diet or accommodation that has been prescribed by a medical authority, or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods). Texture and liquid modifications should align with IDDSI (https://iddsi.org/Framework) recommendations.

SECTION C: SIGNATURES
TO BE COMPLETED BY A STATE-LICENSED HEALTHCARE PROFESSIONAL AND PARENT/GAURDIAN

17. Parent or Guardian Signature: Signature of person requesting the student's medical statement.
18. Date: Print the date the parent or guardian signed the document.
19. Medical Authority Signature: Signature of the medical authority requesting a meal modification or accommodation.
20. Printed Name: Print the name of the Medical Authority requesting a meal modification or accommodation.
21. Telephone Number: Telephone number of the Medical Authority requesting a meal modification or accommodation.
22. Date: Print the date the Medical Authority signed the document.