

### MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

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

1. Program/Provider Name	2. Program/Provider Address	3. Program Telephone Number											
4. Name of Child Participant		5. Age or Date of Birth											
6. Name of Parent or Guardian		7. Telephone Number											
<p><b>8. Check One:</b></p> <p><input type="checkbox"/> Child has a disability, medical condition, food allergy or food intolerance that results in a life-threatening reaction <u>or</u> limits a major life activity (eating, breathing, digestion, respiratory function, etc.) and <b>requires</b> a special meal and/or accommodation. (Refer to definitions on reverse side of this form.) Sites participating in federal nutrition programs <u>must</u> comply with requests for special meals and any adaptive equipment. <b>A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.</b></p> <p><input type="checkbox"/> Child does not have a disability or medical condition that limits a major life activity, but is <b>requesting</b> a special meal or accommodation due to religious, cultural or dietary preference. <u>Any substitutions must fully meet the approved CACFP meal pattern.</u> Sites participating in federal nutrition programs are encouraged to accommodate reasonable requests but are not required to do so. <b>A parent/guardian or adult participant may sign this request.</b></p>													
9. The child's disability or medical condition requiring a special meal or accommodation:													
10. If child has a disability or medical condition impacting a major life activity, provide a brief description of how it affects them:													
11. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):													
<p><b>12. Indicate food texture for above participant:</b></p> <p><input type="checkbox"/> Regular      <input type="checkbox"/> Chopped      <input type="checkbox"/> Ground      <input type="checkbox"/> Pureed</p>													
<p><b>13. 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></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; text-align: center; border: none;"><b>A. Foods To Be Omitted</b></td> <td style="width:50%; text-align: center; border: none;"><b>B. Suggested Substitutions</b></td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> </table>				<b>A. Foods To Be Omitted</b>	<b>B. Suggested Substitutions</b>	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____												
_____	_____												
_____	_____												
_____	_____												
14. Adaptive equipment to be used:													
15. Signature of Parent/Guardian	16. Printed Name	17. Telephone Number	18. Date										
15. Signature of Medical Authority	16. Printed Name (include credentials)	17. Telephone Number	18. Date										

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 (including gender identity and sexual orientation), 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, audiotope, 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 TTY) 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/ad-3027.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](mailto:Program.Intake@usda.gov)

This institution is an equal opportunity provider.

## INSTRUCTIONS

1. **Program/Provider:** Print the name of the site where meals will be served (child care center or provider)
2. **Program/Provider Address:** Print the name of the site address where meals will be served.
3. **Program Telephone Number:** Print the telephone number of site where meals will be served.
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. For infants, please use date of birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **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.).
10. **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; lactose intolerance causes diarrhea).
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by the recognized medical authority.
12. **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".
13. **A. Foods to Be Omitted:** List specific foods that must be omitted (e.g., exclude fluid cow's milk).  
**B. Suggested Substitutions:** List specific foods to include in the diet (e.g., calcium-fortified almond milk).
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
15. **Signature of Parent/Guardian or Medical Authority:** Signature of either the parent/guardian or a recognized medical authority (physician, physician assistant, or nurse practitioner) requesting the special meal or accommodation.
16. **Printed Name:** Print name of parent/guardian or medical authority.
17. **Telephone Number:** Telephone number of parent/guardian or medical authority.
18. **Date:** Date parent/guardian or medical authority signed form.

## DEFINITIONS

**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.