Medical Statement for Meal Modifications in School Nutrition Programs

This form applies to requests for meal modifications for children participating in the U.S. Department of Agriculture's (USDA) school nutrition programs. School nutrition programs include the National School Lunch Program (NSLP), School Breakfast Program (SBP), Afterschool Snack Program (ASSP), Seamless Summer Option (SSO) of the NSLP, Fresh Fruit and Vegetable Program (FFVP), and Child and Adult Care Food Program (CACFP) At-risk Supper Program implemented in schools. Schools and institutions are required to make reasonable meal modifications for children whose physical or mental impairment restricts their diet.

***Note*:** The USDA requires that the medical statement includes: 1) information about the child's physical or mental impairment that is *sufficient to allow the school food authority (SFA) to understand* how the physical or mental impairment restricts the child's diet; 2) *an explanation of what must be done* to accommodate the child's disability; and 3) if appropriate, *the food or foods to be omitted and recommended alternatives*. Schools and institutions should not deny or delay a requested meal modification because the medical statement does not provide sufficient information. When necessary, schools and institutions should work with the child's parent or guardian to obtain the required information. For more information, please reference USDA's 2017 version of Accommodating Children with Disabilities in the School Meal Programs.

Section 1 – Completed by parent or guardian

1. Name of child: _____ 2. Birth date: _____

3. Name of parent or guardian: _____

4. Phone number (with area code): _____ 5. E-mail address: _____

6. Address: _____ City: _____ State: _____ Zip: _____

7. In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act (FERPA), I hereby authorize _____
name of child's state-licensed healthcare professional

to release such protected health information of my child as is necessary for the specific purpose of special diet information to **Franklin Parish School Board** and I consent to allow the recognized medical authority
name of school district

to freely exchange the information listed on this form and in my child's records with the school district as necessary. 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 understand that I may rescind permission to release this information at any time, except when the information has already been released.

8. Signature of parent or guardian: _____ 9. Date: _____

Section 2 – Completed by child's state-licensed healthcare professional

This section must be completed by the child's *physician, physician assistant, or nurse practitioner*.

10. Physical or mental impairment: Does the child have a physical or mental impairment that restricts the child's diet?
☐ No ☐ Yes: Describe how the child's physical or mental impairment restricts the child's diet:

11. ***Diet plan***: Explain the meal modification for the child. Attach a specific diet plan, if needed.

Section 2 – Completed by child's state-licensed healthcare professional, continued

12. Food ***omissions and substitutions***: List foods to be omitted from the child's diet and foods to be substituted.

13. Food texture: List foods that require a change in texture. Indicate "all" if appropriate.

☐ Cut up or chopped into bite-size pieces: _____
☐ Finely ground: _____
☐ Pureed: _____

14. Equipment: List any special equipment or utensils needed.

15. Additional information: Indicate any other information about the child's eating or feeding patterns that will assist in providing the requested meal modification.

16. Name of state-licensed healthcare professional: _____

17. Phone number (with area code): _____

18. Signature of state-licensed healthcare professional: _____ 19. Date: _____

Section 3 – Received by School Food Authority

Date: _____ Received by: _____

Comments:

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Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

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

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