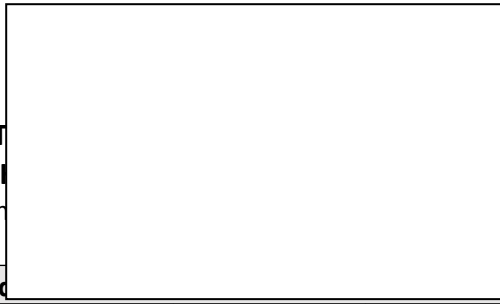


**MEDICAL STATEMENT T  
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Please read guidance and



**DISABILITIES**

g this form.

|   |              |   |                 |
|---|--------------|---|-----------------|
| <b>Part 1: To be completed by Parent/Guardian</b>   |              |   |                 |
| Child's Name  | Age of Child | School Name   | Grade/Classroom |
| Parent/Guardian Name (Please Print)   |              |   |                 |
|   | Phone Number |   | Email Address   |
| Parent's Signature  |              |   | Date            |
| <b>Part 2: Disabilities – Complete all sections applicable.</b>   |              |   |                 |
| Please provide a description of the child's physical or mental impairment and how it restricts the child's diet.  |              |   |                 |
| Please explain how to accommodate the disability.   |              |   |                 |
| List any dietary restrictions or special diet instructions for school meals.  |              |   |                 |
| List food(s) to be omitted from diet:<br>_____<br>_____<br>_____  |              | List food(s) to be substituted:<br>_____<br>_____<br>_____  |                 |
| Designate texture modifications needed for all foods:<br><input type="checkbox"/> Pureed<br><input type="checkbox"/> Diced/finely ground<br><input type="checkbox"/> Chopped/cut into bite-sized pieces |              | Designate consistency for liquids:<br><input type="checkbox"/> Pudding thick <input type="checkbox"/> Nectar thick<br><input type="checkbox"/> Honey thick <input type="checkbox"/> Thin/normal consistency |                 |
| List any special equipment or utensils needed:  |              |   |                 |
| Additional comments about the child's eating or feeding patterns:   |              |   |                 |
| <b>Signature Below (See Guidance and Instructions on page 2)</b>  |              |   |                 |
| Signature of State Licensed Healthcare Professional   |              |   | Date            |
| State Licensed Healthcare Professional's Name, Title & Phone Number (Please Print)  |              |   | Date            |

## **GUIDANCE AND INSTRUCTIONS FOR THE MEDICAL STATEMENT TO REQUEST ACCOMMODATIONS FOR DISABILITIES IN THE SCHOOL MEAL PROGRAMS**

The medical statement on page 1 must be completed and submitted to <insert facility name> before any meal substitutions can be made. If changes are needed, the parent/guardian is required to submit a new form.

### **Guidance**

#### **Disability**

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act (ADAAA) of 2008, “a person with a disability” means 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. According to the ADAAA, most physical and mental impairments constitute a disability.

Major life activities include, but are not limited to, caring for one’s self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentration, thinking, communicating, and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

U.S. Department of Agriculture (USDA) regulations require reasonable modifications to school meals to accommodate children with disabilities when the disability restricts the child’s diet. Modifications will be determined on a case-by-case basis.

**State Licensed Healthcare Professional** is a professional who is authorized to write medical prescriptions under State law. Please refer to the Medical Association of Georgia, *Georgia Prescribers Chart*: <http://www.mag.org/sites/default/files/downloads/georgia-prescribers-chart.pdf>. The decision to permit medical professionals other than licensed physicians to complete and sign a medical statement is at the discretion of the local school food authority.

### **Instructions**

**Part 1:** To be completed by the parent/guardian for all special dietary requests.

**Part 2:** Please provide sufficient detail for the school food service to make appropriate accommodations. This section must be completed by a licensed healthcare professional when the modified meal does not meet the Program meal pattern requirements. The district Section 504 Coordinator, School Food Service Professional and/or other team member will work with you to manage the process of meal modifications.

**Signature:** Signature from a licensed healthcare professional may be required when the reasonable modification does not meet the Program meal pattern requirements.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), 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: mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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