

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

<b>1. District</b> Long Beach Unified School District	<b>2. School Name</b>	<b>3. School Phone Number</b>	
<b>4. Name of Student</b>	<b>5. Student ID #:</b>	<b>6. Date of Birth</b>	
<b>7. Name of Parent or Guardian</b>	<b>8. Telephone Number</b>	<b>9. Meals Needed</b> <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Supper	
<b>10. Description of Child or Participant's Physical or Mental Impairment Affected:</b>			
<b>11. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:</b>			
<b>12. Indicate Food Texture for Above Child or Participant (SELECT ONLY ONE):</b> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <span><input type="checkbox"/> Regular</span> <span><input type="checkbox"/> Chopped</span> <span><input type="checkbox"/> Ground</span> <span><input type="checkbox"/> Pureed</span> </div>			
<b>13. Foods to be Omitted and Appropriate Substitutions:</b>			
<u><b>Foods To Be Omitted</b></u>		<u><b>Suggested Substitutions</b></u>	
<input type="checkbox"/> Fluid Cow's Milk <input type="checkbox"/> Cheese <input type="checkbox"/> Yogurt	<input type="checkbox"/> Soy Milk		
<input type="checkbox"/> All Products with Traces of Dairy	_____		
<input type="checkbox"/> Scrambled Eggs/Egg Patties	_____		
<input type="checkbox"/> All Products with Traces of Egg	_____		
<input type="checkbox"/> Gluten/Wheat	_____		
<input type="checkbox"/> Peanuts/Nuts	_____		
<input type="checkbox"/> Soy Beans (Edamame, Tofu, Soy Milk)	_____		
<input type="checkbox"/> All Products with Traces of Soy	_____		
<input type="checkbox"/> Seafood	_____		
<input type="checkbox"/> Other:	Please Specify: _____		
<b>14. Adaptive Equipment to be Used:</b>			
<b>15. Signature of State Licensed Healthcare Professional*</b>	<b>16. Printed Name</b>	<b>17. Phone Number</b>	<b>18. Date</b>

\*For this purpose, a state licensed healthcare professional in California is a licensed physician, a 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. **District:** Print the name of the district that is providing the form to the parent.
2. **School Name:** Print the name of the site where meals will be served.
3. **School Phone Number:** Print the phone number of site where meal will be served.
4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.
5. **Student ID #:** Print the child or participant's school identification number, if known.
6. **Date of Birth:** Print the date of birth of the child or participant.
7. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.
8. **Telephone Number:** Print the phone number of parent or guardian.
9. **Meals Needed:** Indicate all the meals the child participates in at school.
10. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.
11. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.
12. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".
13. **Foods to be Omitted:** Check or list specific foods that must be omitted (e.g., exclude fluid cow's milk).  
**Suggested Substitutions:** List specific foods to include in the diet (e.g., soy milk).
14. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
15. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
16. **Printed Name:** Print name of state licensed healthcare professional.
17. **Phone Number:** Phone number of state licensed healthcare professional.
18. **Date:** Date state licensed healthcare professional 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.  
**information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.**

**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.