MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. District	2. School Name	3. School Phone Number
Long Beach Unified School District		

4. Name of Student	5. Student ID #:	6. Date of Birth

7. Name of Parent or Guardian	8. Telephone Number	9. Meals Needed
		☐ Breakfast ☐ Lunch ☐ Snack ☐ Supper

10. Description of Child or Participant's Physical or Mental Impairment Affected:

11. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

12. Indicate Food Texture for Above Child or Participant (SELECT ONLY ONE):

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

13. Foods to be Omitted and Appropriate Substitutions:

Foods To Be Omitted	Suggested Substitutions
☐ Fluid Cow's Milk ☐ Cheese ☐ Yogurt	
☐ All Products with Traces of Dairy	☐ Soy Milk
☐ Scrambled Eggs/Egg Patties	
☐ All Products with Traces of Egg	
☐ Gluten/Wheat	
☐ Peanuts/Nuts	
☐ Soy Beans (Edamame, Tofu, Soy Milk)	
☐ All Products with Traces of Soy	
☐ Seafood	
☐ Other:	Please Specify:

14. Adaptive Equipment to be Used:

15. Signature of State Licensed Healthcare Professional*	16. Printed Name	17. Phone Number	18. Date

***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.

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.