

School Town of Munster



Medical Statement for Children with Special Dietary Needs

This statement must be completed and submitted to the Food Service Department before any meal substitutions can be made. The parent/guardian will complete Part 1 and the physician or medical authority will complete either Part 2 **OR** Part 3. Refer to the information below for clarification. Attach a sheet with additional information if necessary. If changes are needed, the parent/guardian is required to submit a new form signed by the child's physician or medical authority.

GUIDANCE

Disability:

Under Section 504 of the *Rehabilitation Act of 1973*, and the *Americans with Disabilities Act (ADA)* of 1990, 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 impairment.

For a list of major life activities, see the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), P.L. 110-325

USDA regulations 7 CFR Part 15b require substitutions or modifications in CACFP meals for children whose disabilities restrict their diets. A child with a disability must be provided substitutions in foods when that need is supported by a statement signed by a licensed physician or a health care provider with prescriptive authority. The statement must identify: the child's disability; an explanation of why the disability restricts the child's diet; the major life activity affected by the disability; the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.

For children who do not have a disability as defined under either Section 504 of the Rehabilitation Act or Part B of IDEA, food service may, but is not required to, make food substitutions for them.

Health care providers with prescriptive authority in Indiana include physicians, physician assistants, and nurse practitioners.

Special Dietary Needs That Are Not a Disability:

Food service may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Such determinations are only made on a case-by-case basis. This provision covers those children who may have food intolerances or allergies that do not limit one or more major life activity, have a record of such impairment, or is regarded as having such impairment.

Each medically based special dietary request must be supported by a statement, which explains the food substitution that is requested. It must be signed by a recognized medical authority. The medical statement must include: an identification of the medical or other special dietary condition which restricts the child's diet; the food or foods to be omitted from the child's diet; and the food or choice of foods to be substituted.

Part 1. To be completed by a Parent, Guardian, or Authorized Representative

Child's name:		Birthday: / /	
Parent/Guardian/Authorized Representative name:			
Home Phone: ()		Work Phone: ()	
Address:			
City:	State:		Zip:

Recognized medical authorities include physicians, physician assistants, and nurse practitioners.

Part 2. For Children with a **DISABILITY-A health care provider with prescriptive authority must complete:**

Describe the patient's disability and the major life activities that are affected by the disability:

Foods to be omitted:

Substitutions:

Please list foods and information regarding any needed texture changes (chopped, ground, pureed, etc):

Please provide any other information regarding the diet:

Part 3. For Children with special dietary needs that are **NOT A DISABILITY-Recognized Medical Authority must complete:**

Describe the medical or other special dietary need that restricts the child's diet:

Foods to be omitted:

Substitutions:

Please list foods and information regarding any needed texture changes (chopped, ground, pureed, etc):

Please provide any other information regarding the diet:

Health Care Provider with Prescriptive Authority/Medical Authority's signature

Date

Printed Name and Title

Telephone