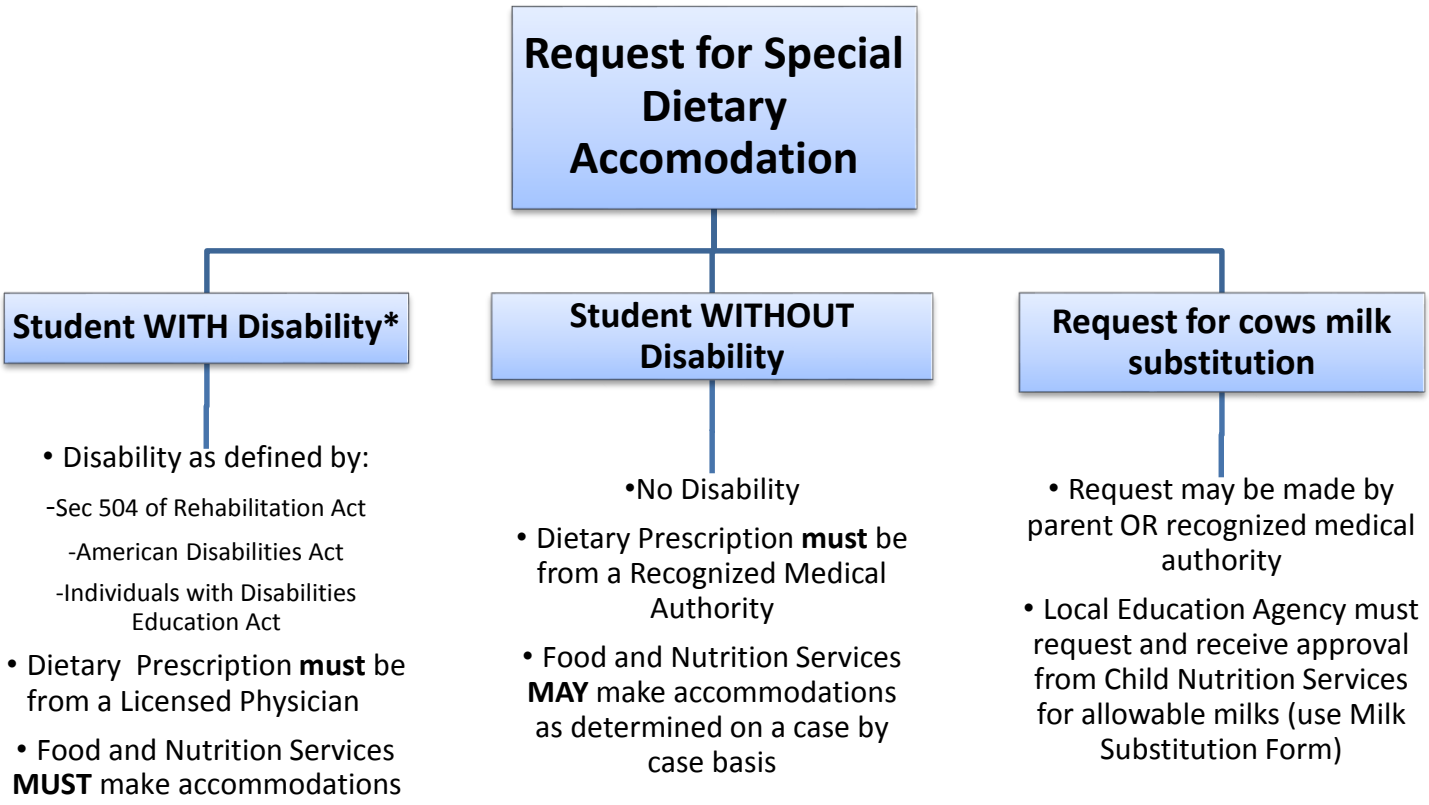
Accommodating Special Dietary Needs

Determining the accommodations to be made AND required documentation



*Disability is determined by a licensed physician

RESOURCES related to Special Dietary REQUESTS

- **US Department of Agriculture Food and Nutrition Service**
  Accommodating Children with Special Dietary Needs in the School Nutrition Programs Guidance for School Food Service Staff
  http://www.fns.usda.gov/cnd/Guidance/special_dietary_needs.pdf

- **Americans with Disabilities Act**
  ADA Homepage: http://www.ada.gov/

- **US Department of Education link for Individuals with Disabilities Education Act (IDEA)**
  http://idea.ed.gov/

Enumclaw SCHOOL DISTRICT

Medical Statement to Request Special Meals and/or 504 Accommodations

Your child's health is important to us. Food and Nutrition Services requires that a Diet Prescription for Meals at School be submitted with information from the parent/guardian and a licensed physician. This form needs to be completed in its entirety before any meal substitutions can be made for children with disabilities. The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's physician. The completed form must be sent to:

Child Nutrition Services
Enumclaw School District
226 Semanski Street S.
Enumclaw, WA 98022

Phone: 360-802-7715
Fax: 360-802-7832

1.Name of Student	**2**.Age or DOB	**3**. Grade	**4**. School
5. Name of Parent, Guardian, or Auth. Rep.	**6**. Telephone (Parent, Guardian, Autho. Rep. ( )		**7**. Site Phone number ( )

8. **Must Check One:**

◯ Student is **disabled** or has a medical condition and *requires* a special meal or accommodation. Sponsors must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

◯ Student is **not disabled,** but is *requesting* a special meal or accommodation. An example may include a food intolerance. **A Recognized Medical Authority (RMA) must sign this form. RMA includes Licensed Physician, Doctor of Osteopathy, Licensed Physician's Assistant, ARNP, or a Licensed Naturopathic Physician.**

9. I give Nutrition Services permission to speak with the Licensed Physician below to discuss the dietary needs described._____(parent/guardian's initials)

10. What is the Student's Diagnosis?_____

11. Is the Student's diagnosis recognized by the ADA as a disability? YES NO

12. If Yes, describe the major life activity affected by the disability:_____

13. Diet prescription and/or accommodations: (Please describe in detail to ensure proper implementation.)_____

_____

14. Potential Length of Service:_____

15. Indicate texture: ◯Regular ◯Chopped ◯Ground ◯Pureed

Foods to be omitted and substitutions: Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

16. Foods to be omitted	**17. Suggested substitutions**
_____	_____
_____	_____
_____	_____

18. Adaptive Equipment:_____

19. Signature of Nurse	**20. Printed Name**	**21. Telephone ( )**	**22. Date**

23. Signature of Medical Authority	24. Printed Name	25. Telephone/Email ( )	26. Date
27. Signature of Parent/Guardian	28. Printed Name	29. Telephone/Email ( )	30. Date

*****Physicians signature is required for students with a disability. For non-disabled students, a licensed physician, physician's assistant, Doctor of Osteopathy, ARNP or a Licensed Naturopathic Physician must sign the form.

For Office Use: Received:_____ Diet Prescription Form: 11/2016

Instructions: Medical Statement to Request Special Meals and/or Accommodations

1. Name of Student
2. Age of Student
3. Grade
4. School
5. Name of Parent, Guardian, or Authorized Representative
6. Telephone: Telephone number of Parent, Guardian, or Authorized Representative
7. Site Telephone: Telephone number of site where meal will be served. See #4
8. Check: Check whether Student is disabled or not disabled.
9. Permission to Nutrition Services to contact Physician for further clarification on diet prescription.
10. Student's Diagnosis?
11. Is the Student's diagnosis recognized by the American with Disability Act (ADA)
12. If Yes - Describe how the physical condition affects disability. For example: "allergy to peanuts causes anaphylactic shock which causes trouble breathing, choking, and potential death unless epinephrine injection is given immediately to the child and the child is sent to the emergency room for follow-up treatment."
13. Diet Prescription and/or Accommodation: Describe specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example, "All foods must be in either liquid or puree form. Child cannot consume any solid foods."
14. Potential Length of Service: Expected length of need for special meal.
15. Indicate Texture: Check the type of texture of food that is required. If the student does not need any modification check "regular"
16. Foods to be omitted: List specific foods that must be omitted. For example, "exclusion of fluid milk" or "No wheat, No milk, Nuts."
17. Suggested Substitutions: List specific foods to include in the diet. For example, "rice flour"
18. Adaptive Equipment: Describe specific equipment required to feed the student. (Examples may include tippy cup, large handled spoon, wheelchair accessible furniture, etc.)
19. Signature of Nurse: Signature of person completing form.
20. Printed Name: Print name of person completing form
21. Telephone: List telephone number of person completing form.
22. Date
23. Signature of medical authority: Signature of medical Authority requesting the special meal or accommodation.
24. Printed name: Print name of medical authority.
25. Telephone: Telephone number of medical authority.
26. Date
27. Signature of parent/guardian
28. Printed name: Print name of parent/guardian
29. Telephone: Telephone number of parent/guardian.

Definitions

"Disabled person" 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 impairment.

"Physical or Mental impairment" means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss of one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory (including speech) organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological

disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. "Has a record of such impairment" is defined as having history of, or has been misclassified as having a mental or physical impairment that substantially limits one or more major life activities.