ST. PATRICK SCHOOL & EDUCATIONAL CENTER

ND

Educating for Life...

MEDICAL STATEMENT FOR MEAL MODIFICATIONS

Students with Disabilities

National School Lunch Program (NSLP) / School Breakfast Program (SBP)
Massachusetts Department of Elementary and Secondary Education (DESE)

This form is used to document a meal modification required because of a student's disability when the modification cannot be accommodated within the applicable USDA meal pattern.

Federal regulations require schools participating in USDA Child Nutrition Programs to make reasonable meal modifications for students whose disabilities restrict their diets. A medical statement may be required when the requested modification is outside the applicable USDA meal pattern.

Please return the completed form to the school or School Food Authority (SFA).

PART A: STUDENT INFORMATION

Student Name: _____

Date of Birth: _____

School: _____

Grade/Classroom: _____

Parent/Guardian Name: _____

Parent/Guardian Phone: _____

Parent/Guardian Email: _____

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PART B: DISABILITY AND DIETARY NEEDS

To be completed by a State-Licensed Healthcare Professional

1. Describe the student's physical or mental impairment and provide sufficient information for the school to understand how the impairment restricts the student's diet:

2. Explain how the student's disability affects the student's ability to eat or participate safely in the school meal program:

PART C: REQUIRED MEAL MODIFICATION

3. Describe the meal modification or accommodation required for the student:

4. Food(s) or ingredient(s) to be OMITTED:

5. Recommended food(s) or ingredient(s) to be SUBSTITUTED or used as alternatives:

_____

_____

6. Is a texture modification required?

□ No
□ Yes

If yes, describe the required texture or consistency, including any applicable instructions for preparation:

_____

_____

7. Are there any other preparation, portion, feeding, or service requirements necessary to safely accommodate the student?

□ No
□ Yes

If yes, please describe:

_____

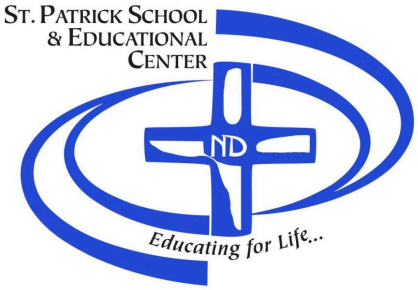
_____

8. Duration of Meal Modification:

□ Temporary — Expected through: _____

□ Ongoing/Indefinite

□ Other: _____



PART D: STATE-LICENSED HEALTHCARE PROFESSIONAL CERTIFICATION

I certify that the information provided above describes the meal modification necessary to accommodate this student's disability.

Name of State-Licensed Healthcare Professional:

Professional Title/Credentials:

Practice/Organization:

Phone Number: _____

Email: _____

Signature: _____

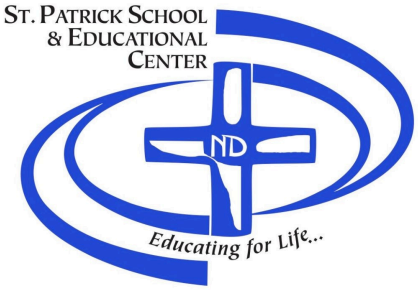
Date: _____

PART E: PARENT/GUARDIAN ACKNOWLEDGMENT

I understand that the school nutrition program will use the information provided on this form to develop and implement an appropriate meal modification for my child.

I agree to notify the school if my child's dietary needs or required meal modifications change.

Parent/Guardian Name: _____



Phone Number: _____

Email: _____

Signature: _____

Date: _____

PART F: SCHOOL/SFA USE ONLY

Date Form Received: _____

Received By: _____

Date Modification Implemented: _____

School Nutrition/Food Service Contact:

_____

Accommodation/Meal Modification Implemented:

_____

_____

Additional Notes:

_____

_____

_____

IMPORTANT INFORMATION FOR FAMILIES

Students with disabilities must be provided reasonable meal modifications when necessary to ensure equal access to USDA Child Nutrition Programs.

When a student's needs can be accommodated within the USDA meal pattern, a medical statement may not be required. When a disability requires a meal modification outside the applicable meal pattern, appropriate documentation must be maintained in accordance with USDA and Massachusetts DESE requirements.

The school will work with the student's parent/guardian and, when appropriate, the student's healthcare provider to ensure that the student's dietary needs are safely and appropriately accommodated.

A disability-related meal modification will not result in an additional charge to the student.

USDA NONDISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language) should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete Form AD-3027, USDA Program Discrimination Complaint Form, which can be obtained online, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number,

and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.

The completed AD-3027 form or letter must be submitted 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: (833) 256-1665 or (202) 690-7442

Email: program.intake@usda.gov

This institution is an equal opportunity provider.