

**MEDICAL STATEMENT  
TO REQUEST  
SPECIAL MEALS and/or ACCOMMODATIONS**

(1) Name of Child	(2) Date of Birth	(3) Name of Child Care Provider	(4) CNP Provider Number
(5) Name of Parent or Guardian	(6) Telephone Number (Parent or Guardian) (    )		(7) Provider's Telephone Number (    )
(8) Must check one: <input type="checkbox"/> Child is disabled or has a medical condition and <i>requires</i> a special meal or accommodation. (Refer to definition on reverse side of this form.) Provider must comply with requests for special meals and any adaptive equipment. <b>A physician must complete and sign this form.</b>  <input type="checkbox"/> Child is not disabled, but a <i>request</i> for a special meal or accommodation is being made. An example may include a food intolerance. <b>However, food preferences are not included as an example.</b> Providers are encouraged to accommodate reasonable requests. <b>A physician, physician's assistant, or a nurse must complete and sign this form.</b>			

(9) Disability or medical condition requiring a special meal or accommodation: \_\_\_\_\_  
\_\_\_\_\_

(10) If child is disabled, provide a brief description of child's major life activity affected by disability:  
\_\_\_\_\_  
\_\_\_\_\_

(11) Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation) \_\_\_\_\_  
\_\_\_\_\_

(12) Indicate texture:     Regular     Chopped     Ground     Pureed

**Foods to be omitted and substitutions:** Please list specific foods to be omitted and suggest substitutions. You may attach a sheet with additional information if necessary.

(13) Foods to be omitted

(14) Suggested substitutions


(15) Adaptive Equipment: \_\_\_\_\_

(16) Signature of Medical Authority*	(17) Printed Name	(18) Telephone Number (    )	(19) Date
(20) Medical Authority's* License Number	(21) Medical Authority's* Address, City, State, and Zip		

\*For a child with a disability, a physician must complete and sign this form.  
For a non-disabled child, a nurse, physician's assistant or physician may complete and sign this form.

The information on this form should be updated to reflect the current medical and/or nutritional needs of the child

The USDA and NSD are equal opportunity providers and employers.

# INSTRUCTIONS

- 1) Name of Child
- 2) Date of Birth
- 3) Name of Child Care Provider
- 4) CNP Provider Number
- 5) Name of Parent or Guardian
- 6) Telephone Number: phone number of guardian or parent
- 7) Provider's Telephone Number: Telephone number of site where meal will be served, See #4.
- 8) Check: Check whether participant is disabled or not disabled.
- 9) Disability or Medical Condition Requiring a Special Meal: Describe medical condition that requires a special meal or accommodation. (e.g., juvenile diabetes, allergy to peanuts).
- 10) If Child is Disabled, Provide a Brief Description of Child's Major Life Activity Affected by Disability: Describe how physical condition affects disability. For example: "Allergy to peanuts causes anaphyloid 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."
- 11) 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 either in liquid or pureed form. Child cannot consume any solid foods."
- 12) Indicate Texture: Check the type of texture of food that is required. If the child does not need any modification check "regular."
- 13) Foods to be Omitted: List specific foods that must be omitted. For example, "exclusion of fluid milk."
- 14) Suggested Substitutions: List specific foods to include in the diet. For example, "lactose reduced milk, calcium fortified juice."
- 15) Adaptive Equipment: Describe specific equipment required to feed the participant. (Examples may include tippy cup, large handled spoon, wheel-chair accessible furniture etc.)
- 16) Signature of Medical Authority: Signature of physician.
- 17) Printed Name: Print name of physician.
- 18) Telephone Number: Telephone number of physician.
- 19) Date
- 20) Medical Authority's License Number
- 21) Medical Authority's Address

**"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 an impairment or is regarded as having such an impairment.

**"Physical or mental impairment"** means (1) 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 (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 one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. "Has a record of such an impairment" **is defined as having a history of, or has been misclassified as having a mental or physical impairment that substantially limits one or more major life activities.**