THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
FOOD AND NUTRITION SERVICES

MENU MODIFICATION MEDICAL STATEMENT

TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS FROM SCHOOL CAFETERIA

1. School Name	2. School Phone Number
3. Student Name	4. Age or Date of Birth
5. Parent/Guardian Name	6. Phone Number

7. Check One:

☐ The student has a disability or a medical condition and requires a special meal or accommodation (Refer to the definitions on page 2). Schools participating in the National School Lunch Program must comply with requests for special meals and any adaptive equipment. A licensed physician must sign this form.

☐ The student does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools participating in the National School Lunch Program are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, or nurse practitioner must sign this form.

8. Disability or medical condition requiring a special meal or accommodation

9. Does the student receive meals from the school cafeteria? Indicate breakfast, lunch, after school snacks.

10. If the student has a disability, provide a brief description of the student's major life activity affected by the disability

11. Diet prescription and/or accommodation (Describe in detail to ensure proper implementation– use extra pages if needed.)

12. Indicate texture

☐ Regular, no alteration ☐ Chopped ☐ Ground ☐ Pureed ☐ Liquid

13. Foods to be omitted and substitutions (List specific foods to be omitted and suggested substitutions – use extra pages if needed).

Foods to be Omitted	Suggested Substitutions

14. Adaptive Equipment

15. Parent/Guardian Signature			16. Date
17. Preparer Signature	18. Printed Name		19. Date
20. Medical Authority Signature*	21. Printed Name	22. Phone Number	23. Date

*A physician's signature is required for students with a disability. For students without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.

INTERNAL USE ONLY:

Date Received by School	Date Placed in Student Health Record	Date Copy Given to Food Service
Recipient Signature	Filer Signature	Recipient Signature

The School Board of Sarasota County, Florida, complies with State Statutes on Veteran's Preference and Federal Statute on non-discrimination on the basis of race, color, sex, religion, national origin, age, handicap, disabilities, marital status, or sexual orientation.

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INSTRUCTIONS

1. **School Name**: Print the name of the school that is providing the form to the parent or guardian.
2. **School Telephone Number**: Print the telephone number of the school.
3. **Student Name**: Print the name of the student to whom the information pertains.
4. **Age or Date of Birth**: Print the age of the student. For infants, please use date of birth.
5. **Parent or Guardian Name**: Print the name of the person requesting the student's medical statement.
6. **Telephone Number**: Print the telephone number of the parent or guardian.
7. **Check One**: Check (✓) a box to indicate whether the student has a disability or does not have a disability.
8. **Disability or Medical Condition Requiring a Special Meal or Accommodation**: Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc).
9. **Does the student receive meals from the school cafeteria**? Please indicate breakfast, lunch, after school snacks. This helps Food and Nutrition Services determine if a personalized menu is needed. If the child does not receive meals from the cafeteria, then this request form will remain on school campus and applied towards foods eaten outside of the cafeteria, i.e. classroom snacks.
10. **If the Student has a Disability, Provide a Brief Description of the Student's Major Life Activity Affected by the Disability**: Describe how the physical or medical condition affects the student (e.g., allergy to peanuts causes a life-threatening reaction).
11. **Diet Prescription and/or Accommodation**: Describe a specific diet or accommodation that has been prescribed by a physician, or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods).
12. **Indicate Texture**: Check (✓) a box to indicate the type of texture of food that is required. If the student does not need any modification, check "Regular."
13. **Foods to be Omitted**: List specific foods that must be omitted (e.g., exclude fluid milk)
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium fortified milk)
14. **Adaptive Equipment**: Describe specific equipment required to assist the participant with dining (e.g., a sippy cup, a large handled spoon)
15. **Parent or Guardian Signature**: Signature of person requesting the student's medical statement.
16. **Date**: Print the date the parent or guardian signed the document.
17. **Preparer's Signature**: Signature of person completing the form.
18. **Printed Name**: Print the name of the person completing the form.
19. **Date**: Print the date the preparer signed the form.
20. **Medical Authority's Signature**: Signature of the medical authority requesting the special meal or accommodation.
21. **Printed Name**: Print the name of the medical authority.
22. **Telephone Number**: Print the telephone number of the medical authority.
23. **Date**: Print the date the medical authority signed the form.

DEFINITIONS*

"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, including 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.

"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.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)

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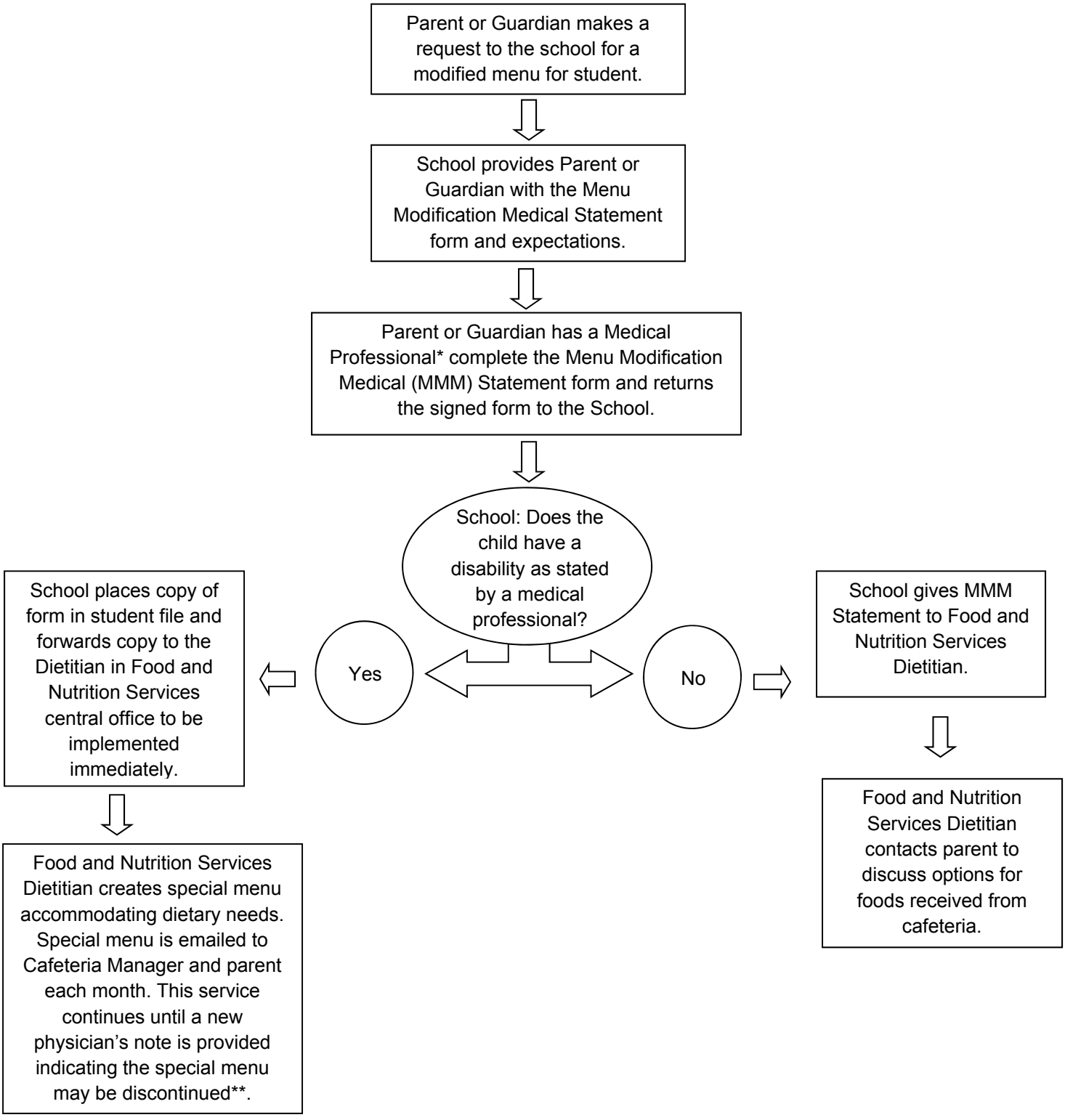
SUGGESTED FLOW FOR HANDLING MENU MODIFICATION REQUESTS



*A physician's signature is required for students with a disability. For students without a disability, a licensed physician, physician's assistant, or nurse practitioner may sign the form.

**Once a physician's note is received and dietary accommodations are made, Food and Nutrition Services requires a new physician's note indicating the allergies no longer exist in order to be discontinued.