CNS ONLY	
Date received:	
Noted on POS:	
Lead notified:	

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

ORDERED BY PHYSICIAN ☐ **REQUESTED BY PARENT** ☐

1. School/Agency Name	2. Site Name	3. Site Telephone Number

4. Name of Participant	5. Age or Date of Birth
6. Name of Parent or Guardian	**7. Telephone Number**

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant 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 and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

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

11. Diet prescription and/or accommodation: (***please describe in detail to ensure proper implementation-use extra pages as needed***)

12. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. Foods to be omitted and substitutions: (***please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed***)

A. Foods To Be Omitted	B. Suggested Substitutions

14. Adaptive Equipment:

15. Signature of Preparer*	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority*	**20. Printed Name**	**21. Telephone Number**	**22. Date**

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

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