

McMinnville School District Medical Statement to Request Special Meals and/or Accommodations

Federal law and USDA regulation require Child Nutrition Programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal dietary preferences.

Site/Provider Name:	Submit this form to: McMinnville School District, Nutrition Services
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Part I To be completed by Parent/Guardian, Adult Participant, or McMinnville School District

Name of Participant: <hr/>
Parent/Guardian Name: _____ Phone #: _____

Part II To be completed only by a State licensed health care professional who is authorized to write medical prescriptions under State law* or a Registered Dietitian** (CACFP and SNP only).

1. Describe the major life activity or major bodily function(s) affected by the participant's physical or mental impairment that restricts the diet: <hr/> <hr/>						
2. Meal Accommodation Plan (Foods to omit or avoid): <hr/> <hr/>						
3. Foods to be substituted and recommended alternatives (include modification and accommodation): <hr/> <hr/>						
Signature of State Licensed Health Care Professional* or Registered Dietitian**: <table style="width: 100%;"><tr><td style="width: 33%;"><hr/></td><td style="width: 33%;"><hr/></td><td style="width: 33%;"><hr/></td></tr><tr><td style="text-align: center;">Printed Name</td><td style="text-align: center;">Signature</td><td style="text-align: center;">Date</td></tr></table>	<hr/>	<hr/>	<hr/>	Printed Name	Signature	Date
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Printed Name	Signature	Date				

Part III McMinnville School District Use Only

Accommodation(s) Made: <hr/> <hr/>
Sponsor Signature: _____ Date: _____

Instructions for completing the Meal Preference Request Form:

1. **Organization Name:** Include the name of the Sponsoring Organization that is providing the form
2. **Site/Provider Name:** Print the name of the site where meals will be served (e.g., ABC School, XYZ Child Care Center)
3. **Submit this form to:** Include the name and contact information for the organization staff who will be collecting the completed form
4. **Part I:** This section can be completed by the **Parent/Guardian, Adult Participant, or Organization**
 - a. **Name of Participant:** Print the first and last name of the child or adult participant
 - b. **Parent/Guardian Name:** Print the first and last name(s) of the parent or guardian. This is not required for adult participants.
 - c. **Phone #:** Include a number for the parent/guardian in case of questions
5. **Part II:** This section must be completed by a **State licensed health care professional*:**
 - a. In section 1 – **Describe:** The major life activity or major bodily function affected by the participant's physical or mental impairment that restricts the diet.
 - b. In section 2 – **Meal Accommodation Plan:** Provide any foods to omit or avoid.
 - c. In section 3 – **Foods to be substituted and recommended alternatives:** Provide the modification and accommodation.
6. **Part III:** This section must be completed by the Sponsoring Organization after Parts I and II are completed.
 - a. **Accommodations Made:** The Sponsoring Organization staff will indicate what accommodations will be made for the requests made in Part II.
 - b. **Sponsor Signature and Date:** The Sponsoring Organization staff will sign and date the form. This form will be considered incomplete if this section is not filled in.

This form is only for participants requiring a medical meal accommodation and should be filled out by a licensed medical professional*. Participants requesting a Non-Medical Meal Accommodation and/or a Milk Substitution will use the Meal Preference Request Form.

***State License Health Care Professionals include: Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified Nurse Practitioner(CNP) or Clinical Nurse Specialist (CNS) Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD). **Registered Dietitian (RD/RDN) are authorized by USDA in 7 CFR 210.10(m) and 7 CFR 226.20(g)(1) to complete and sign medical statements for SNP and CACFP participants.**

This institution is an equal opportunity provider.