Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

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**

Part I To be completed by Parent/Guardian, Adult Participant, or McMinnville School District

Name of Participant:
_____

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*. Complete questions 1-3.

1. **Describe** the major life activity or major bodily function(s) affected by the participant's physical or mental impairment that restricts the diet:

_____
_____

2. **Meal Accommodation Plan (Foods to omit or avoid):**

_____
_____

3. **Foods to be substituted and recommended alternatives (include modification and accommodation):**

_____
_____

Signature of State Licensed Health Care Professional:

_____ _____ _____
Printed Name Signature Date

Part III McMinnville School District Use Only

Accommodation(s) Made:
_____
_____
Sponsor Signature: _____ Date: _____

Rev 4/21

This institution is an equal opportunity provider

.

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

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 Accomodation 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 Professions** include: Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD).