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

Child Nutrition Programs
(503) 947-5894

# Silver Falls 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:** |
|---|---|
| | |

**Part I** To be completed by Parent/Guardian, Adult Participant, or Silver Falls SD

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** Silver Falls SD Use Only

Accommodation(s) Made: _____

_____

Sponsor Signature: _____ Date: _____

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## 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).