MICHIGAN Department of Education

Michigan Department of Education
Office of Health and Nutrition Services

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant. See back side for instructions.

1. School/Agency Name:	2. Site Name:	3. Site Telephone:
4. Name of Participant/Student:		5. Participant Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐Participant has a disability and *requires* a special meal or accommodation (Refer to instructions 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. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP).**

☐Participant does not have a disability, but is requesting a special meal or accommodation due to religious, cultural, economic, or other preferences. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests but are not required to do so. Any meals provided must fully meet the meal pattern. **A school administrator or parent/guardian may sign this form.**

☐Participant *does not have a disability*, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), nurse, school administrator, or parent/guardian may 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; see instructions on reverse side*)

12. Specific 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; see reverse side*)

A. Food(s) To Be Omitted: **B. Suggested Substitution(s)**

_____

_____

13. Indicate Texture:

☐Regular ☐Chopped ☐Ground ☐Pureed

14. Adaptive Equipment Needed (if applicable):

15. Signature of Parent/Guardian:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority (if applicable):	20. Printed Name: (include credentials and license/registration number)	21. Telephone	22. Date