Medical Statement to Request Special Meals and/or Accommodations

(Hot Sheet)

CF/H-14c (CNP-925) Revised 1/11

(mandatory)

This form is mandatory for all programs serving children under Child Nutrition Programs.

School Nutrition Program Guidance Manual and Head Start Performance Standards (1304.23(c)(6) requires that children with food allergies needing special meals / accommodations have a signed statement from their physician regarding the respective allergy and recommended substitutes.

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.

2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)

3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.

4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.

5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.

6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.

7. **Telephone Number:** Print the telephone number of parent or guardian.

8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.

9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).

10. **If participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."

11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."

12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".

13. A. **Food to be Omitted:** List specific foods that must be omitted. For example, the exclude fluid milk."
    B. **Suggested Substitution:** List specific foods to include in the diet. For example, "calcium fortified juice."

14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)

15. **Signature of Preparer:** Signature of person completing form.

16. **Printed Name:** Print name of person completing form.

17. **Telephone Number:** Telephone number of person completing form.

18. **Date:** Date preparer signed form.

19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal of accommodation.

20. **Printed Name:** Print name of medical authority.

21. **Telephone Number:** Telephone number of medical authority.

22. **Date:** Date medical authority signed form.

23. Physician returns completed form to health staff.

24. Distribute white copy to the Teacher or Family Child Care Home, yellow copy to the Delegate Director and the pink copy for the health file.

25. Ensure that all persons involved in food service, including substitute teachers, are advised of the daily diet accommodation for the respective student.