Updated 5/2015

Michigan Department of Education
Office of School Support Services

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

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

8. Check One:

☐ Participant has a disability or a medical condition 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 food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), or speech pathologist must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, registered dietitian, nurse practitioner, parent, or 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*)

12. 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.*)

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

13. Indicate Texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Adaptive Equipment:

15. Signature of Preparer:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority:	20. Printed Name: (include credentials)	21. Telephone	22. Date