



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 as necessary to reflect the current needs of the participant.

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:	
<p>8. Check One:</p> <p><input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> 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).</p> <p><input type="checkbox"/> 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. A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP), speech pathologist, or parent/guardian must sign this form.</p> <p><input type="checkbox"/> Participant <i>does not have a disability</i>, 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), or parent/guardian may sign this form.</p>					
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. 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:					
<input type="checkbox"/> Regular		<input type="checkbox"/> Chopped		<input type="checkbox"/> Ground	
				<input type="checkbox"/> Pureed	
14. Adaptive Equipment Needed (if applicable):					
15. Signature of Preparer:		16. Printed Name:		17. Telephone:	
19. Signature of Medical Authority:		20. Printed Name: (include credentials and license/registration number)		21. Telephone	
				22. Date	