

GUIDANCE AND INSTRUCTIONS TO REQUEST ACCOMMODATIONS FOR SPECIAL DIETARY NEEDS IN THE SCHOOL MEAL PROGRAMS

The medical statement on page 1 must be completed and submitted to <insert facility name> before any meal substitutions can be made. If changes are needed, the parent/guardian is required to submit a new form.

Guidance

Disability

Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act (ADAAA) of 2008, "a person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. According to the ADAAA, most physical and mental impairments constitute a disability.

Major life activities include, but are not limited to, caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentration, thinking, communicating, and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

U.S. Department of Agriculture (USDA) regulations require reasonable modifications to school meals to accommodate children with disabilities when the disability restricts the child's diet. Modifications will be determined on a case-by-case basis.

Accommodations for special dietary requests that can be made within the Program meal pattern requirements do not require a medical statement. The School Food Authority may require a medical statement signed by a State licensed healthcare professional be submitted to accommodate the request.

State Licensed Healthcare Professional is a professional who is authorized to write medical prescriptions under State law, and may include a physician, nurse practitioner, or a physician's assistant. Please refer to the Medical Association of Georgia, **Georgia Prescribers Chart**: <http://www.mag.org/sites/default/files/downloads/georgia-prescribers-chart.pdf>.

Instructions

Part 1: To be completed by the parent/guardian for all special dietary requests.

Part 2: Please provide sufficient detail for the school food service to make appropriate accommodations. This section must be completed and signed by a State licensed healthcare professional when the modified meal does not meet the Program meal pattern requirements. The district Section 504 Coordinator, School Food Service Professional and/or other team member will work with you to manage the process of meal modifications.

Signature: Signature from a State licensed healthcare professional is required when the reasonable modification does not meet the Program meal pattern requirements.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

**STATEMENT TO REQUEST ACCOMMODATIONS FOR SPECIAL DIETARY NEEDS
IN THE SCHOOL MEAL PROGRAMS**

Please read guidance and instructions on page 2 before completing this form.

Part 1: To be completed by Parent/Guardian			
Child's Name	Age of Child	School Name	Grade/Classroom
Parent/Guardian Name (Please Print)	Phone Number	Email Address	
Parent's Signature			Date
Part 2: Disabilities – Complete all sections applicable.			
Please provide a description of the child's physical or mental impairment and how it restricts the child's diet.			
Please explain how to accommodate the disability.			
List any dietary restrictions or special diet instructions for school meals.			
List food(s) to be omitted from diet: _____ _____ _____		List food(s) to be substituted: _____ _____ _____	
Designate texture modifications needed for all foods: <input type="checkbox"/> Pureed <input type="checkbox"/> Diced/finely ground <input type="checkbox"/> Chopped/cut into bite-sized pieces		Designate consistency for liquids: <input type="checkbox"/> Pudding thick <input type="checkbox"/> Nectar thick <input type="checkbox"/> Honey thick <input type="checkbox"/> Thin/normal consistency	
List any special equipment or utensils needed:			
Additional comments about the child's eating or feeding patterns:			
Signature Below (See Guidance and Instructions on page 2). Required for accommodations outside the meal pattern.			
Signature of State Licensed Healthcare Professional			Date
State Licensed Healthcare Professional's Name, Title & Phone Number (Please Print)			Date