GARDEN GROVE UNIFIED SCHOOL DISTRICT
FOOD SERVICES DEPARTMENT

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL	2. SITE NURSE	3. SITE TELEPHONE NUMBER
4. NAME OF PARTICIPANT	5. STUDENT #	6. AGE OR DATE OF BIRTH
7. Meal I.D. #	8. STATUS	9. DOES STUDENT EAT SCHOOL LUNCH DAILY? (CHECK ONE) YES NO
10. NAME OF PARENT OR GUARDIAN		11. TELEPHONE NUMBER

12. CHECK ONE

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions 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. **A licensed physician must sign this form.**

☐ 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, physician's assistant, or registered nurse must sign this form.**

13. DISABILITY OR MEDICAL CONDITION REQUIRING A SPECIAL MEAL OR ACCOMMODATION:

14. IF PARTICIPANT HAS A DISABILITY, PROVIDE A BRIEF DESCRIPTION OF PARTICIPANT'S MAJOR LIFE ACTIVITY AFFECTED BY THE DISABILITY

15. DIET PRESCRIPTION AND/OR ACCOMMODATION: ***(PLEASE DESCRIBE IN DETAIL TO ENSURE PROPER IMPLEMENTATION)***

16. INDICATE TEXTURE:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

17. FOODS TO BE OMITTED AND SUBSTITUTIONS: ***(PLEASE LIST SPECIFIC FOODS TO BE OMITTED AND SUGGESTED SUBSTITUTIONS. YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)***

A. Foods To Be Omitted	B. Suggested Substitutions

18. ARE THE FOODS TO BE OMITTED WHOLE FOODS AND/OR FOODS AS AN INGREDIENT? ***(EX.: WHOLE EGG ONLY, EGG AS AN INGREDIENT)***

19. IF LACTOSE INTOLERANT, OMIT FLUID MILK ONLY, OR ALL DAIRY? ***(I.E. CHEESE, YOGURT, MILK AS AN INGREDIENT)***

20. SIGNATURE OF PREPARER *	21. PRINTED NAME	22. TELEPHONE NUMBER	23. DATE
24. SIGNATURE OF MEDICAL AUTHORITY *	25. PRINTED NAME	26. TELEPHONE NUMBER	27. DATE

* **Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or registered nurse must sign the form.**

A licensed physician's report and the information on this form must be updated annually

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