Medical Statement to Request Meal Modification

Modifications to Accommodate a Disability: Meal modifications prescribed by a licensed healthcare professional must be made to accommodate a participant's disability.

Definition of Disability: Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as 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. "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include 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.

This form must be completed by a "licensed healthcare professional" that is authorized by Kansas state law to write medical prescriptions [a licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced practice registered nurse (APRN) authorized by their responsible licensed physician] or a registered dietitian.

Part A. Participant, Parent/Guardian, Facility Contact Information – To be completed by a parent/guardian or facility contact person.

Participant's Name:	Date of Birth:	Facility:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
Facility Contact's Name:	Facility Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Description of the physical or mental impairment related to the prescribed diet order and major life activity affected.
   Example: Allergy to peanuts affects ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Special Feeding Equipment _____
(e.g. large handled spoon, sippy cup, etc.)

3. Medical Authority's Information:

Signature: Title:

Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for facility personnel responsible for implementing the prescribed diet order to discuss the special dietary accommodations with any appropriate staff and to follow the prescribed diet order for meals. I also give permission for the medical authority to further clarify the prescribed diet order on this form if requested to do so by facility personnel.

Parent/Guardian's Signature: Date:

This institution is an equal opportunity provider.