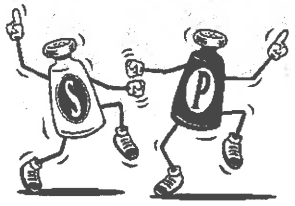
MORONGO UNIFIED SCHOOL DISTRICT



Nutritional Services
PO Box 1209
Twentynine Palms, Ca 92277

According to our school records your child has food allergies. In order to best serve your child additional information is needed. Please have the enclosed form completed by your child's physician and return it in the enclosed envelope.

We appreciate your assistance in this matter. If you have any question, please call (760) 367.9191 or (760) 365.3394, Ext. 4263.

Thank you,

Janet Barth, SNS

Janet Barth, SNS
Director, Nutritional Services

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. A. **Foods to Be Omitted:** List specific foods that must be omitted. For example, the "exclude fluid milk."
    B. **Suggested Substitutions:** List specific foods to include in the diet. For example, "calcium fortified juice."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

DEFINITIONS*:

"A Person with a Disability" is defined 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.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973)

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY	2. SITE	3. SITE TELEPHONE NUMBER

4. NAME OF PARTICIPANT	5. AGE OR DATE OF BIRTH

6. NAME OF PARENT OR GUARDIAN	7. TELEPHONE NUMBER

8. 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.**

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)*

12. INDICATE TEXTURE:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. 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

14. ADAPTIVE EQUIPMENT:

15. SIGNATURE OF PREPARER*	16. PRINTED NAME	17. TELEPHONE NUMBER	18. DATE
19. SIGNATURE OF MEDICAL AUTHORITY*	**20. PRINTED NAME**	**21. TELEPHONE NUMBER**	**22. 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.**

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

MORONGO UNIFIED SCHOOL DISTRICT
HEALTH SERVICES

EMERGENCY MEDICATION AUTHORIZATION

DATE: _____

_____ **(Child's name)** has been instructed in the proper use of the _____. We, _____ **(Physician)** and _____ **(Parent)** request that _____ **(child)** be permitted to carry _____ on his/her person, as we consider him/her responsible. S/he has been instructed in and understands the purpose and appropriate method and frequency of use of his/her emergency medication.

IT IS UNDERSTOOD THAT SHARING MEDICATION WITH OTHERS WILL RESULT IN DISCIPLINARY ACTION.

A new EMERGENCY MEDICATION AUTHORIZATION form is required each school year and any time the dosage, time, or type of medication changes.

Diagnosis:

_____

_____ _____

Physician's signature & Office Stamp Parent's signature

NOTE: THIS FORM MUST BE COMPLETED IN ADDITION TO THE ROUTINE DISTRICT MEDICATION AUTHORIZATION FORM