Medical Statement for Students with Unique Mealtime Needs

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), and U.S. Office for Civil Rights (OCR) for meal modifications in any Child Nutrition Program.

PART A *(To be completed by **PARENT/GUARDIAN**)*

STUDENT INFORMATION	**Last Name:**	**First Name:**	**Middle Name:**	**Date of Birth**
	School:		**Grade/Age**	**Student ID# or Meal #**
SELECT the Program: (Select all that apply)	☐ **School Breakfast Program (SBP)** ☐ **National School Lunch Program (NSLP)** ☐ **Afterschool Snack Program (ASP)** ☐ **Fresh Fruit & Vegetable Program (FFVP)** ☐ **Child and Adult Child Care Program (CACFP)** ☐ **Summer Food Service Program (SFSP)**			
PARENT/GUARDIAN CONTACT INFORMATION	**Printed Name of PARENT/GUARDIAN:**			
	Mailing Address:	**City:**	**State:**	**Zip Code:**
	Work Phone: / **Island**	**Cell Phone:**	**Email:**	
Please describe the concerns you have about your student's nutritional needs:				
Please describe the concerns you have about your student's ability to safely participate:				

Does the student have an Individualized Education Program (IEP)?
☐ YES ☐ NO

Does the student have a 504 Plan?
☐ YES ☐ NO

***NOTE:** Unique mealtime needs for students without an IEP, 504 or disability, but with general health concerns, are addressed within the meal pattern at the discretion of the School, CACFP or SFSP Sponsor.*

PARENT/GUARDIAN Consent

I agree to allow my child's health care provider and school personnel to communicate as needed regarding the information on this form.

Parent/Guardian Signature **Date**

Please return this fully completed Medical Statement with signatures from both parent/guardian and medical authority, to your child's school, CACFP or SFSP provider.