MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. Agency Name	2. Site Name	3. Site Phone Number
4. Name of Child or Adult Participant		**5. Age or Date of Birth**
6. Name of Parent or Guardian		**7. Phone Number**

8. Check One:

☐ Participant has a disability or a medical condition that **requires** a special meal and/or accommodation. (Refer to definitions on reverse side of this form.) Agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment.

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to a food intolerance or other medical reason. Food preferences are not an appropriate use of this form. Agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests.

A licensed physician, physician assistant, or nurse practitioner must complete and sign this form.

9. The participant's disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of his/her major life activity affected by the disability:

11. Diet prescription and/or accommodation (please describe in detail to ensure proper implementation-use extra pages as needed):

12. Indicate food texture for above participant:

☐ 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 as needed):

A. Foods To Be Omitted	B. Suggested Substitutions

14. Adaptive equipment to be used:

15. Signature of Recognized Medical Authority*	16. Printed Name	17. Phone Number	18. Date

***For this purpose, a recognized medical authority in Oklahoma is a licensed physician, physician assistant, or nurse practitioner.**

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

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