

United States Department of Agriculture

Food and Nutrition Service Instruction 783-2

7 CFR PART 15b

“Handicapped person” means any person who has a physical or mental impairment which substantially limits one or more major life activities, has record of such an impairment, or is regarded as having such an impairment.

“Physical or mental impairment” means (1) any physiological disorder or condition, cosmetic disfiguration, or anatomical loss affecting one or more of the following body systems:

Neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic skin, and endocrine or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term “physical or mental impairment” includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction, and alcoholism.

“Major life activities” means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

## Medical Statement for Student Requiring Special Meals

Name of Student:	School District:
Birth Date:	School Attended:
Parent Name:	Telephone:
Telephone:	

### For Physician's Use

Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).

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### Diet Prescription (check all that apply):

- ☐ Diabetic (include calorie level or attach meal plan)    ☐ Modified Texture and/or Liquids  
☐ Reduced Calorie    ☐ Food Allergy (describe): \_\_\_\_\_  
☐ Increased Calorie    ☐ Other (describe): \_\_\_\_\_

### Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

#### OMITTED FOODS

#### SUBSTITUTIONS

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### Indicate Texture:

- ☐ Regular    ☐ Chopped    ☐ Ground    ☐ Pureed

### Indicate thickness of liquids:

- ☐ Regular    ☐ Nectar    ☐ Honey    ☐ Pudding

### ☐ Special Feeding Equipment

Additional comments: \_\_\_\_\_

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Preparer or Other Contact

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

I hereby give my permission for the school staff to follow the above stated nutrition plan.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

Revised 6/99