

Letter to Parent/Guardian Explaining Requirements for School Meal Modification Requests

Dear Parent/Guardian:

Your child's school:

1. Will make meal modifications prescribed by a licensed physician to accommodate a disability.
2. Does not make meal modifications prescribed by a medical authority due to a food allergy/intolerance or other medical condition that does not rise to the level of a disability.
3. Does not make substitutions for fluid cow's milk due to a food allergy/intolerance or for other reasons.

The Medical Statement to Request School Meal Modification is attached to this letter. On the front of that form there is further information about the three categories of meal modifications that can be requested under federal regulations, and the procedures that apply to each category. Please read this information carefully before completing the form. Only the types of meal modifications explained in the first paragraph of this letter are applicable to your child's school.

To ensure the requested meal modifications can be made on the first day of school, return the completed medical statement by August 8, 2018 to District Office at 119 S. Main, Inman, KS 67546

If you are submitting a request for meal modification at a time other than the beginning of the school year, it will take approximately ten (10) school days from the time the request is received until it can be implemented.

Sincerely,

Scott Friesen
Superintendent

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: program.intake@usda.gov.

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Medical Statement to Request Meal Modification

Modifications to Accommodate a Disability: Meal modifications prescribed by a medical authority 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 "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (APRN) authorized by their responsible licensed physician.

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| 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. <i>Example: Allergy to peanuts affects ability to breathe.</i> | | |
| 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: | <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed |
| Modified Thickness of Liquids: | <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Nectar <input type="checkbox"/> Honey <input type="checkbox"/> Spoon or Pudding Thick |
| Special Feeding Equipment: | <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Special Feeding Equipment _____ <small>(e.g. large handled spoon, sippy cup, etc.)</small> |
| 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: | |

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