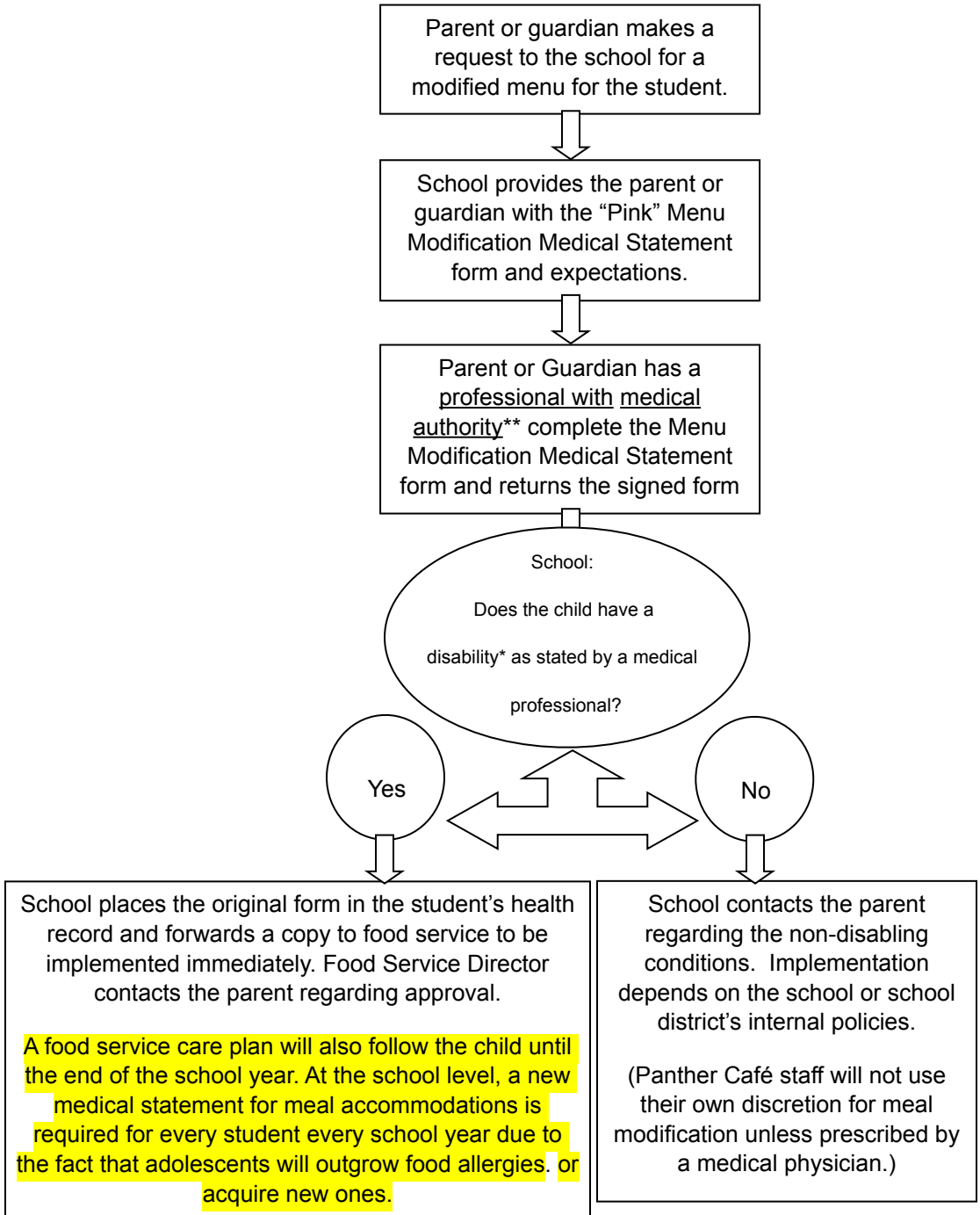
BASILICA SCHOOL OF SAINT PAUL
SUGGESTED FLOW FOR HANDLING MENU MODIFICATION REQUESTS

Updated at Sponsor site level on June 14, 2022 By: S. Robinson, CFSM



** For students with a disability, a state licensed health care professional authorized to write medical prescriptions must sign this form. Includes: Licensed Physicians (MD, DO), Advanced Registered Nurse Practitioners (ARNP), and Physician's Assistants (PA).

Keep all files for 5 years – Label Food Service Meal Modification Plans

DEFINITIONS*

"A Person with a disability" is defined as any person who has a physical or mental impairment that 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, Genitourinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental illness and specific learning disabilities.

"Major life activities" 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.

"Has a record of such an impairment" is defined as having a history of or has 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 AND
AMERICANS WITH DISABILITIES ACT OF 1990)

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS INSTRUCTIONS

1. **School Name**: Print the name of the school that is providing the form to the parent or guardian.
2. **School Telephone Number**: Print the telephone number of the school.
3. **Student Name**: Print the name of the student to whom the information pertains.
4. **Age or Date of Birth**: Print the age of the student. For infants, please use date of birth.
5. **Parent or Guardian Name**: Print the name of the person requesting the student's medical statement.
6. **Telephone Number**: Print the telephone number of the parent or guardian.
7. **Check One**: Check (✓) a box to indicate whether the student has a disability or does not have a disability.
8. **Disability or Medical Condition Requiring a Special Meal or Accommodation**: Describe the medical condition that requires a special meal or accommodation (e.g., Type 1 or 2 diabetes, life threatening allergy, etc.).
9. **If the Student has a disability, provide a description of the student's Major Life Activity affected by the disability**: Describe how the physical or medical condition affects the student (e.g., allergy to peanuts causes a life-threatening reaction).
10. **Diet Prescription and/or Accommodation**: Describe a specific diet (or accommodation (e.g., soft foods) that has been prescribed by a physician or describe a diet modification requested for a non-disabling condition (e.g., all foods must be either in liquid or pureed form; student cannot eat solid foods).
11. **Indicate Texture**: Check (✓) a box to indicate the type of texture accommodation of foods that is needed. If the student does not need any texture modification, skip this question.
12. **Foods to be Omitted**: List specific foods that must be omitted (e.g., exclude fluid milk). If specific foods do not need to be omitted, skip this question.
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified milk).
13. **Adaptive Equipment**: Describe specific equipment required to assist the participant with dining (e.g., a sippy cup, a large handled spoon, suction plate).
14. **Parent or Guardian Signature**: Signature of the person requesting the student's medical statement.
15. **Date**: Print the date the parent or guardian signed the document.
16. **Preparer's Signature**: Signature of the person completing the form.
17. **Printed Name**: Print the name of the person completing the form.
18. **Date**: Print the date the preparer signed the form.
19. **Medical Authority's Signature**: Signature of the medical authority requesting a special meal or accommodation.
20. **Printed Name**: Print the name of the medical authority.
21. **Telephone Number**: Print the telephone number of the medical authority.
22. **Date**: Print the date the medical authority signed the form.

MEDICAL STATEMENT TO REQUEST*

SPECIAL MEALS AND/OR ACCOMMODATIONS

Keep all files for 5 years – Label Food Service Meal Modification Plans

1. School Name / Address	2. School Telephone Number
Basilica School of Saint Paul *317 Mullally Street* *Daytona Beach, Florida 32117*	**(386) 252-7915**
3. Student Name	**4. Age or Date of Birth**
5. Parent or Guardian Name	**6. Telephone Number**

7. Check One:

The student has a disability or a medical condition and requires a special meal or accommodation (Refer to the definitions on page 2). Schools participating in the National School Lunch Program must comply with requests for special meals and any adaptive equipment. A state licensed health care professional authorized to write medical prescriptions must sign this form.

The student 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 participating in the National School Lunch Program are encouraged to accommodate reasonable requests.

8. Disability or medical condition requiring a special meal or accommodation:

9. If the student has a disability, provide a brief description of the student's major life activity affected by the disability:

10. Diet prescription and/or accommodation:
Please describe in detail to ensure proper implementation – use extra pages if needed.

11. Indicate texture modification request (if applicable):
Ground Soft Pureed Liquid

12. Foods to be omitted and substitutions (if applicable): *Please note suggestions are respected however the Food Service Director or Coordinator will have the final discretion due to supply and demand challenges in the industry.*
Please list specific foods to be omitted and suggested substitutions – use the back side of this page if necessary.

Foods to be Omitted	Suggested Substitutions
_____	_____
_____	_____

13. Adaptive Equipment:

14. Parent of Guardian Signature			15. Date
16. Preparer's Signature	**17. Printed Name**		**18. Date**
19. Medical Authority's Signature*	**20. Printed Name**	**21. Telephone Number**	**22. Date**

* For students with a disability, a state licensed health care professional authorized to write medical prescriptions must sign this form.
* Includes: Licensed Physicians (MD, DO), Advanced Registered Nurse Practitioners (ARNP), and Physician's Assistants (PA).

INTERNAL USE ONLY:

Date Received by School: Recipients Signature:	Date Received and Filed by FSD: Recipients Signature:	Date Filed in Front Office: Filer's Signature

Foods to be omitted and substitutions

(Continuation of #12)

Continued only with the intended purpose of provided additional space from question #12 on the front side of this form.

12. Foods to be omitted and substitutions (if applicable): *Please note suggestions are respected however the Food Service Director or Coordinator will have the final discretion due to supply and demand challenges in the industry.*
Please list specific foods to be omitted and suggested substitutions – use the back side of this page if necessary.

Foods to be Omitted	Suggested Substitutions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____