Information on Accommodations to School Meals for Students with a Medical Disability

The National School Lunch Program (NSLP) and School Breakfast Program (SBP) must provide reasonable accommodations for students with medical disabilities.

The Code of Federal Regulations (7 CFR, Part 15b) defines a person with a disability as (1) having a physical or mental impairment that substantially limits one or more major life activities and (2) having a record or is regarded as having a physical or mental impairment.

Schools may also provide accommodations for special medical or dietary needs that restrict a student's diet but are not considered a medical disability.

For an NSLP or SBP site to provide a meal accommodation for a student with a medical disability, the parent or guardian must provide a medical statement signed by medical authority who is licensed by the State to write prescriptions. For this purpose, State is defined as the State of Texas. Any medical authority whose prescription is allowed to be filled by a pharmacy located in Texas under Texas law and regulation may provide a medical statement for a meal accommodation.

The medical statement must include the following information in order for the Contracting Entity to make the meal accommodation:

1. Statement explaining the student's medical disability which includes a description that is sufficient to allow the school to understand how this condition restricts the student's diet

2. Description of the accommodation to be made: food items or ingredients to be omitted, food items ingredients to be substituted, modified food texture, and/or other accommodation

   If the medical statement requires substitutions, the medical statement should include a list of food or beverage items that are appropriate substitutions. Also note, a school is not required to provide a name brand product if another product with the same specifications is available.

If the licensed medical authority does not provide a medical statement that includes the information listed above, the school cannot make a meal accommodation.

When a school believes the medical statement is unclear or lacks sufficient detail, the school must request appropriate clarification so that a proper and safe meal can be provided. When clarification is provided, any changes to the medical statement must be provided in writing before the school implements the changes.

Request for Dietary Accommodation
Galena Park ISD Solicitud para
Acomodaciones Dietéticos Distrito
Escolar Independiente Galena Park ISD

Instructions: Parent or Guardian completes PART A. Physician completes PART B. School Nurse completes PART C. Nurse to keep a copy. Make copy for cafeteria or scan and e-mail to cafeteria. Cafeteria will contact and send to food service office. Parent or Guardian and School Nurse will be notified after request is evaluated. Form is required annually.
Instrucciones: Padre o Tutor completa PARTE A. El Médico completa PARTE B. Enfermera Escolar completa PARTE C. Padre o Tutor y Enfermera de la escuela serán notificados despuás de evaluar la solicitud. Se requiere la forma anualmente.

PART A / PARTE A			
Student's Name (Nombre del estudiante):		Age (Edad):	Student ID (Identificación del estudiante):
School (Escuela):	Grade (Grado) :	Classroom (Salón):	
Printed Parent or Guardian's Name(Nombre de impresa del Padre o Tutor):		E-mail (Dirección Electrónica): Phone (Teléfono):	
PART B / PARTE B			
Physician licensed to practice medicine in the state of Texas is required to complete PART B and sign.			
1. Does the Child have a disability recognized by the American's with Disability Act (ADA)?		YES	NO If No, skip to Question # 3
2. If YES, please identify the disability and describe the major life activities affected by the disability.			
3. If the Child does not have a disability, does the child have a food allergy that results in an anaphylactic reaction when exposed to the food(s) to which they have problems?		YES	NO
4. If the Child does not have a disability and does not have a food allergy that results in an anaphylactic reaction when exposed to food, does the child have a food intolerance?		YES	NO
5. . If the answer to Questions 1, 2 OR 3 is YES, please circle the following that affect the child. Dairy_____ Egg_____ Egg White _____ Gluten_____ Nut(s)____ Soy_____ PKU ____ Other:_____ Any additional information:			
6.. For food texture modification. List the foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "all (a) Cut up or chopped into bite size pieces. (b) Finely ground (c) Pureed or Blended			
7. Indicate any other comments about the child's eating or feeding patterns.			
Licensed physician's printed or stamped name		Office Phone: Office Fax:	
Licensed physician's signature:			Date:
PART C / PARTE C			
School Nurse:		Phone:	
8. Does the Child have "Individualized Health Care Plan" (IHCP).		YES	NO
9. Does the Child have a 504 Plan?		YES	NO