

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS and/or ACCOMMODATION

(1) Name of Participant	(2) DOB	(3) School Early Childhood Education	(4) Site
(5) Name of Parent, Guardian, or Auth. Rep	(6) Telephone (Parent, Guardian or Auth. Rep.)	(7) Site Telephone Number 661-273-4710	

(8) Disability or medical condition requiring a special meal or accommodation: _____

(9) Explanation of Diet Prescription and/or Accommodation (Please describe in detail to ensure proper implementation): _____

(10) Indicate food texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Foods to be omitted and appropriate substitutions: Please list specific foods to be omitted and suggested substitutions.

****If lactose intolerant please specify to remove all dairy products or specify if cheese and yogurt are permitted. The only allowable substitutes for fluid cow's milk are lactose free milk and soymilk.***

(11) Foods to be OMITTED	(12) SUBSTITUTIONS (*REQUIRED*)

(13) Adaptive Equipment: _____

(14) Signature of State Licensed Healthcare Professional*	(15) Printed Name	(16) Telephone	(17) Date

***For this purpose, a state licensed healthcare professional in California is a physician, physician's assistant, or a nurse practitioner.**

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