MEAL CHANGE REQUEST FORM INSTRUCTIONS

Important! Carefully read and follow the steps for the meal change request. If the form is not complete, the Harrisburg School District will follow up with the parent/guardian about the request. **We recommend that you keep a copy of the form that is turned into to the Harrisburg School District.** If you have any questions about this form, contact the Harrisburg School District.

Definitions:

- **'HSD'** is the Harrisburg School District.
- A **'participant'** would be a student, child, or adult (in a day care setting) who receives meals at the Harrisburg School District.

Note to Parent/Guardian/Participant: As required in FNS Instruction 783, Rev. 2, Section V Cooperation: When working with a meal change request, food service staff should work closely with the parent(s) / guardian(s) / participant(s) or responsible family member(s) and with all other medical and community personnel who are responsible for the health, well-being and education of a participant with a condition that limits a major life activity to ensure that reasonable steps are taken that will allow the individual's participation in the meal service.

1. **Meal Change Request due to a condition that limits a major life activity:**
   - HSD **must** provide a meal change for a condition that limits a major life activity. You will find more information about what is considered a major life activity below. A participant does not need to be labeled as having a 'disability' in order to need a meal change.
   - If you are asking for a meal change that is based on a condition that limits a major life activity, a meal change request form (alternate form allowed) is required and it must be signed by a recognized medical authority. A recognized medical authority is a medical official who is authorized to write prescriptions. The following sections must be completed when submitting a change request for this reason.
     - Part A of this form must be completed by the parent/guardian/participant.
     - Part B of this form must be completed by a recognized medical authority when the meal change requires HSD to provide a meal outside of the meal pattern. HSD staff can help the parent/guardian/doctor to understand what the meal patterns require.
     - We strongly recommend the parent/guardian signs Part D of the form.
   - HSD will require a completed meal change form that is signed by a recognized medical authority. If a signed meal change form is requested by HSD, then HSD must provide the alternate meal while waiting for the signed form.
   - A meal change request based on a condition that limits a major life activity will be followed by HSD until a parent/guardian/recognized medical authority tells HSD that the change request is no longer needed. HSD may ask for a signed statement to document the end of the meal change request.
   - We strongly recommended that parents/guardians look at the change request each year to make sure the change is still correct and needed

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42 USC § 12102 – DEFINITION OF DISABILITY

(1) Disability

The term "disability" means, with respect to an individual—

(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment (as described in paragraph (3)).

(2) Major life activities

(A) In general

For purposes of paragraph (1), 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.

(B) Major bodily functions

For purposes of paragraph (1), a major life activity also includes the 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.

(3) Regarded as having such an impairment

For purposes of paragraph (1) (C):

(A) An individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.

A participant does not need to be labeled with a 'disability' in order to need a meal change.

Definition of Recognized Medical Authority

Per USDA Memos SP 26-2017, CACFP 14-2017, and SFSP 10-2017, a State licensed healthcare professional authorized to write medical prescriptions can sign the medical statement.

In addition to Medical Doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioner, and Physician Assistant (PA), the South Dakota Board of Osteopathic Medical Examiners identify Certified Nurse Practitioners (CNP) and Certified Nurse Midwives (CNM) as capable of writing prescriptions, thus identified as recognized medical authorities who may sign a Meal Change Request.

The licensing of physicians (pursuant to SDCL 36-4-9) does not include chiropractors, opticians, dentists, orthodontists, or physical therapists. Although some of the above-named healthcare providers use the title "Dr." in front of their name, only physicians licensed pursuant to SDCL 36-4-9 may append the letters M.D. or D.O. to their name (SDCL 36-4-9). Therefore, signatures on Meal Change Requests based on conditions that affects major life activities will be considered valid only if the physician uses, or is licensed to use, M.D. or D.O. after his/her name.

A parent who is an M.D., D.O., PA, CNP, or CNM may sign his or her own child's meal change request.

MEAL CHANGE REQUEST FORM

*** Keep a copy of the completed form for your records.**

Part A – Participant, Parent/Guardian, and HSD Contact Information – To be completed by a parent/guardian or HSD contact person –

1. School/Agency Name	2. School Name (eg. Liberty)	3. HSD Telephone
Harrisburg School District		**605-743-2567**
4. Name of Participant/Student		**5. Date of Birth**
6. Name of Parent or Guardian		**7. Parent/Guardian Telephone**

Part B – Meal Change – To be completed by a medical authority (State licensed healthcare professional authorized to write prescriptions) if change is outside of the meal pattern. HSD can help you to understand what the meal patterns require.

8. Check One:

☐ a. Participant has a **condition which limits a major life activity**.

☐ b. Participant does not have a condition which limits a major life activity.

9. State the condition, food allergy/intolerance, medical condition, or reason a meal change is required/requested (use extra pages if needed):

10. If the participant has a condition that limits a major life activity (see definition on instructions page)**, provide a brief description of the major life activity** (see list on instructions page) **affected by the condition** (e.g. allergy to peanuts affects ability to breathe)**:**

☐ Check if not applicable

11. Modified Texture:		12. Modified Thickness:	
☐ Not Applicable	☐ Chopped	☐ Not Applicable	☐ Nectar
☐ Ground	☐ Pureed	☐ Honey	☐ Spoon or Pudding Thick

13. Foods to be omitted and substituted: (List specific foods to be omitted and suggested substitutions. You may sign and attach a separate page with more information if needed.)

☐ Check if not applicable

A. Foods To Be Omitted	B. Suggested Substitutions

14. Additional Information: (Such as special feeding equipment, type of meal modification, etc.).

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Part C – Request Change for Fluid Cow's Milk

15. These are the fluid cow's milk substitutions allowed by USDA and available from HSD:

(a) Lactose-free fluid cow's milk,

(b) Buttermilk,

(d) Soy Milk

(e) Rice Milk

Instead of fluid cow's milk, please provide the individual named in Part A of this form with the following substitute (check ONE):

☐ Lactose-free milk ☐ Buttermilk ☐ Soy milk ☐ Rice Milk

16. Signature of Preparer (When Medical Authority is not required)	**17. Printed Name**	**18. Telephone Number**	**19. Date**
20. Signature of Medical Authority/Title	**21. Printed Name**	**22. Telephone Number**	**23. Date**

Part D – Parent/Guardian Permission – To be completed by a parent/guardian (not required, but encouraged)

I give permission for school/agency personnel responsible for implementing my child's meal modification to discuss my child's meal change with any appropriate school/agency staff and to follow the meal modification for my child's school/agency meals. I also give permission for my child's medical authority to further clarify the meal modification on this form if requested to do so by school/agency personnel.

24. Parent/Guardian Signature:	**25. Date:**

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(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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