

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

USD 217 Rolla Schools 203 Van Buren P.O. Box 167 Rolla, Ks 67954 (620)-593-4345

August 1, 2023

Dear Parent/Guardian:

Your student's school will make meal modifications prescribed by a licensed medical authority that is authorized by Kansas state law to write medical prescriptions (MD, DO, PA, or APRN) to accommodate a disability. A prototype *Medical Statement to Request School Meal Modification* is attached to this letter and can be used to request a meal modification.

**IMPORTANT:** For a student who does not have a disability, a request for meal modifications can be made and the school **MAY** choose to make substitutions. Any modification of this kind must meet the reimbursable meal pattern.

If you have questions or need assistance, please call Jamie Milburn at (620)-593-4345.

Sincerely,



Jamie Milburn  
JH/HS Secretary

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
- (2) **fax:**  
(833) 256-1665 or (202) 690-7442; or
- (3) **email:**  
[program.intake@usda.gov](mailto: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 practice registered nurse (APRN) authorized by their responsible licensed physician.**

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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