# Summer Food Service Program (SFSP)
# Form 307 Medical Statement

Dear Parent/Guardian:

This sponsor participates in the Summer Food Service Program (SFSP) and must serve meals and snacks meeting the SFSP requirements. If a participant has a documented disability that restricts his/her diet, the sponsor must make reasonable modifications to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet as prescribed by a State Licensed Healthcare Professional.

If a participant has a documented physical or mental impairment that restricts his/her diet, the sponsor must have a medical statement from a Licensed Healthcare Professional (Physician, Nurse Practitioner, or Registered Dietitian), the sponsor at their discretion may provide a substitution to the meal plan and/or modification to the meal service, including necessary aids and services. Please have your State Licensed Healthcare Professional complete and sign this form. Return the completed form to the sponsor in which your child is enrolled for the SFSP.

Note to Sponsor: Parents/Guardians may provide a written request for lactose-reduced milk without a Licensed Healthcare Professional's signature.

Submit this completed medical statement form to: _____
**Name of Sponsor**

## Participant Information

Participant's Name: _____ Today's Date: _____
Last/First/Middle Initial

Name of School/Center/Site Attended: _____ Date of Birth: _____

Parent/Guardian Name: _____

Home Phone Number: _____ Work Phone Number: _____

## Required Information: Dietary Accommodation

1. State the allergen or food to be avoided:
   _____
2. Brief explanation of how exposure to allergen or food affects the participant:
   _____
3. List specific foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

| Foods to be Omitted | Foods to be Substituted |
|---|---|
| | |
| | |
| | |

## Additional Information

Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other: _____

Tube Feeding- Formula Name: _____

Administering Instructions: _____

Oral Feeding: ☐ No ☐ Yes If yes, specify food: _____

Other Dietary Modification(s) or Additional Instructions (describe): _____

## Signature

Licensed Physician, Physician Assistant, Registered Dietitian, or advanced practice Registered Nurse such as a certified Nurse Practitioner must sign and retain a copy of this document.

Prescribing Authority Credentials (print):_____ Date: _____

Signature:_____ Clinic/Hospital:_____

Phone Number:_____ Fax Number: _____

**Voluntary Authorization:** Note to Guardian(s)/Participant: You may authorize the director of the school/center/site to clarify this Special Diet Statement with the physician by signing the following Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to_____**(program name)** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. Optional: My permission to release this information will expire on_____**(date)**. This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian:_____Date:_____

OR Participant's Signature (Adult Day Care): _____

## Non-Discrimination Statement

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/ad-3027.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

(2) fax: (838) 256-1665 or (202) 690-7442; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

**Instructions for Completing the**
**Medical Statement for SFSP Participants**
**Requiring Meal Modifications**

**Sponsor Name:** Provide the legal name as it appears in the SFSP online application.

**Participant Information:**

1. Provide the name of the participant who needs the modified meal.
2. Complete today's date as MM/DD/YYYY
3. Complete the site/organization the child attends
4. Provide the date of birth of the participant as MM/DD/YYYY.
5. List the parent/guardian's name
6. Provide the best number for home (or cell) and work, as applicable

**Required Information: Dietary Accommodation**

1. List the allergens or food to be avoided.
2. Briefly describe how exposure to this food/allergen affects the participant.
3. List the foods that must be omitted on the left side of the chart. For each food that must be omitted from the participant's diet list an alternate substitute on the right side of the chart.

**Additional Information:**

If the texture meal modification is required, select the texture modification, or specify other.
If the Tube Feeding is required, specify the formula name, and complete the administering instructions.
If there are additional information the sponsor needs to know concerning oral feeding, select yes and specify the food and instructions.
As feasible, indicate other dietary modification and/or clearly describe additional instructions.

**Signature:**

The Licensed Health Care Provider will complete the prescribing authority credentials, the date of the signing, signature, clinic/office/hospital, and phone/fax number.

**Voluntary Authorization**

This section allows the parent/guardian the opportunity to authorize the sponsor to clarify the special diet statement with the physician to better accommodate the participant's special needs. Parent/guardian shall complete this section in its entirety, as feasible.

**Note: Disability (formerly known as Handicapped Participant) or Medical Condition 7 CFR Subtitle A, Section 15b.3(i) Definitions**

(i) *A person with a "disability"* means any person who has a "physical or mental impairment which substantially limits one or more major life activities of such individual; has a record of such impairment or is regarded as having such an impairment."

(ii) The Americans with Disabilities Act Amendments Act of 2008 (ADAAA) broadened the list of "Major Life Activities" for purposes of identifying individuals with disabilities and added a new category called "Major Bodily Functions." As amended by the ADAAA, Major Life Activities now also include Major Bodily Functions.