2021-2022 SMUSD CNS MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS -
PLEASE FAX DIRECTLY TO CNS – FAX# (760) 752-1137

2021-2022 DECLARACIÓN MÉDICA de CNS PARA SOLICITAR COMIDAS Y ALOJAMIENTOS ESPECIALES –
POR FAVOR ENVIE UN FAX DIRECTAMENTE a CNS (760)752-1137

1. NAME OF PARTICIPANT/STUDENT/NOMBRE DEL ESTUDIANTE	2. DATE OF BIRTH—FECHA DE NACIMIENTO _____	3. SPONSOR/PATROCINADOR SMUSD	4. STUDENT'S SCHOOL SITE/ESCUELA DE ESTUDIANTE _____
5. SCHOOL SITE TELEPHONE NUMBER/NÚMERO DE TELÉFONO ESCOLAR (760) -	6. NAME OF PARENT/GUARDIAN—NOMBRE DEL PADRE/TUTOR _____	7. E-MAIL PARENT/GUARDIAN—CORREO ELCTRÓNICO DEL PADRE/TUTOR _____	

8. SIGNATURE OF PARENT/GUARDIAN (REQUIRED) —FIRMA DEL PADRE/TUTOR

The District is required to comply with state and federal laws protecting the release of student and medical records, including, but not limited to, the Family Educational Rights and Privacy Act, 20 USC 1232g (FERPA) and Education Code Section 49060 et seq. / El Distrito se requiere cumplir con leyes del Estado y leyes federales protegiendo la liberación de estudiante y archivos médicos, incluso, pero no limitado con, la Familia Derechos Educativos y Acto de Intimidad, 20 USC 1232g (FERPA) y el Artículo 49060 del Código de la Educación y seq.

9. TELEPHONE PARENT/GUARDIAN—TELÉFONO PADRE/TUTOR (TRABAJO)	10. TELEPHONE PARENT/GUARDIAN—TELÉFONO PADRE/TUTOR (CASA)	11. TELEPHONE GUARDIAN—TELÉFONO PADRE/TUTOR (CELLULAR OR MÓVIL)	12. ___/___/_____ DATE SIGNED PARENT/GUARDIAN / FECHA DE LA FIRMA PADRE/TUTOR
WORK ( )	HOME ( )	CELL ( )	

13. WILL YOUR CHILD BE BUYING/RECEIVING MEALS FROM THE CAFETERIA? YES OR NO / EL NIÑO SE COMPRA/RECIBIR COMIDAS EN LA CAFETERIA?
SI O NO ☐ Yes/Si (Please continue/Por Favor continúe) ☐ No (Stop-Do not complete form/Para aqui no complete el formulario
☐ Do not Serve my student (Call 760-752-1286) / No sirven a mi estudiante (Llamada 760-752-1253)

Note: You must have or set up a prepaid account. Nota: Usted debe tener o configurar una cuenta prepagada.
(CHECK ALL THAT APPLY/MARQUE TODO LO QUE APLICATE) ☐**Breakfast/Desayuno:** ☐Daily/Diaria or/o ☐ Not Daily/No Diaria
☐**Lunch/Almuerzos:** ☐Daily/Diarios or/o ☐Not Daily/No Diarios ☐**Supper/Cena:** ☐Daily/Diaria or/o ☐ Not Daily/No Diaria

IMPORTANT/IMPORTANTE #14 through #21 To Be Completed By Medical Authority Only. Thank you! Los números 14 por 21 Sera completados por un médico sólo - Gracias

14. Description of Child's Physical or Mental Impairment Affected: **Personal food preferences are not an appropriate use of this form and will not be honored.**

_____

_____

_____

DIAGNOSIS: _____

15. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

_____

_____

_____

Attach a second sheet if needed and be sure to complete each section below to better assist us. Thank you!

CA Licensed Healthcare Professional

16. (LACTAID MILK AVAILABLE AT ALL SITES)
ALLERGIC TO:
√ CHECK ALL THAT APPLY AND COMPLETE A & B

☐ Egg * ☐ Shellfish
☐ Gluten ☐ Soy *
☐ Milk * ☐ Tree Nuts
☐ Peanut ☐ Wheat
☐ Other (Be specific):

Let us know

_____

_____

REDUCED CALORIE ☐ **Breakfast** ☐ **Lunch**
EPI PEN AT SCHOOL?: ☐ Yes ☐ No

A. Ingredient(s)/Food(s) To Be Omitted
(PLEASE LIST SPECIFIC INGREDIENT)

_____

_____

_____

_____

_____

_____

ALLERGEN BAKED IN OKAY FOR:
○ EGG ○ MILK ○ DAIRY
○ SOY ○ OTHER _____
(√ CHECK ALL THAT APPLY)

(INDICATE FOOD TEXTURE FOR CHILD IF NEEDED)
○ REGULAR ○ CHOPPED ○ GROUND ○ PUREED

B. Suggested Substitutions (Please List)
List Specific Food Groups if necessary with % of fat (ex. <30%) or an actual amount
(PLEASE ATTACH ADDITIONAL SHEET IF NEEDED)

_____

_____

_____

_____

_____

_____

ADAPTIVE EQUIPMENT TO BE USED:

CA Licensed Healthcare Professional

17. SIGNATURE (REQUIRED) SIGNATURE OF CA LICENSED HEALTHCARE PROFESSIONAL* SIGN BELOW: _____ Circle One: *Licensed Physician / Physician Assistant Nurse Practitioner (recognized in CA)	18. PRINTED NAME NAME:_____ Circle One: Please stamp if available or list clinic name CLINIC NAME/ADDRESS:	19. TELEPHONE NO. ( ) 20. FAX NO. ( )	21.DATE / / (DD/MM/YY) (REQUIRED) Please be sure entire form is complete!	CA LICENSED HEALTHCARE PROFESSIONAL

NOTE: The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant. (Asked to be completed yearly)

Instructions / Instruccións SMUSD CNS 2021 -2022 Medical Statement Cont'd

NOTE: Parent/Guardian—Please Complete Number 1-13 Only
Los Números 14 por 30 Sera Completados por un médico sólo - Gracias

1. **Name of Child/Student:** Print the name of the child or participant to whom the information pertains.
   Nombre del Estudiante: Imprima el nombre del niño o paricipant adulto a quien la información pertenece a.
2. Print the Date of Birth of the participant. For infants, please use Date of Birth.
   Edad Fecha de Nacimiento: Imprimir la edad y la fecha de nacimiento del participante. para los bebés, por favor nos fecha de nacimiento
3. **Sponsor: SMUSD** is the name of the agency that is providing the form to the parent./ **Patrocinador - SMUSD**
4. **School Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
   Escuela de estudiante: Imprimir el nombre de la escuela donde las comidas se sirven (por ejemplo, centro de cuidado infantil, centro comunitario)
5. **School Site Telephone Number:** Print the telephone number of the site where meals will be served (#4 above)
   Número de teléfono escolar: Imprimir el número de teléfono de la escuela donde se servirá la comida.
6. **Name of Parent/Guardian:** Print the name of the person requesting child's medical statement.
   Nombre del Padre/Tutor: Imprimir el nombre de la persona que solicita la declaración médica del participante.
7. **E-Mail Parent/Guardian:** Print the e-mail of the parent/guardian.
   Correo electrónico del Padre/Tutor: Imprimir el correo electrónico de los padres o tutores.
8. **Signature of Parent/Guardian:** Signature of Parent/Guardian completing form. Items 5-12 (Required to be complete for any student)
   Firma del Padre/Tutor: Firma de los padres o tutores completando el formulario (artículos 5-12) - Necesario completar para cualquier estudiante)

9-11. **Telephone Numbers:** Print the telephone numbers of parent/guardian—please list all available.
Imprimir los números de teléfono: De los padre/tutore—enumere todas disponibles. **Teléfono padre/tutor** (trabajo) **Teléfono padre/tutor (casa) Teléfono padre/tutor (cellular or móvil)**

12. **Date Signed:** Date signed by the parent/guardian.
    Fecha de la firma: Fecha de la firma padre/tutor.
13. **Buying/Receiving Meals from Cafeteria:** Check (✓) yes or no. Breakfast and/or Lunch and how often?
    El niño se compra/recibir comidas en la cafetería? Sí o no – Marca (✓)El desayuno y/o el almuerzo y con qué frecuencia?

NOTE: Physician/Medical Authority—Please Complete Number 14-21 / Los Números 14 por 21 Sera Completados por un Médico Sólo - Gracias

14. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.
15. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.
16. **Allergic to:** Check (✓) a box to indicate all that apply, and complete A & B and for Other be specific.
    Reduced Calorie: Check (✓) breakfast and/or lunch. (Cafeteria will follow current procedures.)
    Epi Pen at School?: Check (✓) Yes or No.
    - **A. Ingredient(s) to Be Omitted:** List specific ingredient(s) that must be omitted. For example, "exclude fluid milk." Ingredient okay if baked in for any item listed (bubble)
    - **B. Required Substitutions:** List specific foods and food groups to include in the diet. For example, "calcium fortified juice." Be specific with % of fat (ex. <30% or actual amount. This is helpful in determining our menu items to omit.

    NOTE: INDICATE FOOD TEXTURE FOR CHILD IF NEEDED OR ANY ADAPTIVE EQUIPMENT TO BE USED
17. **Signature of CA Licensed Healthcare Professional and Include stamp and name of clinic if applicable:**
18. **Printed Name:** Print name of CA Licensed Healthcare Professional. (physician, physician assistant, or a nurse practitioner)
19. **Telephone Number:** Telephone number of CA Licensed Healthcare Professional. (physician, physician assistant, or a nurse practitioner)
20. **Fax Number:** Fax number of CA Licensed Healthcare Professional. (physician, physician assistant, or a nurse practitioner)
21. **Date:** Date of CA Licensed Healthcare Professional. (physician, physician assistant, or a nurse practitioner) signed form. (Required)

DEFINITIONS

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:
A person with a disability is defined 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.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

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.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.

DEFINICIONES*:

"Una persona con discapacidad" se define como toda persona que tiene un impedimento físico o mental que limita una o más de las actividades principales de su vida, tiene un historial de tal impedimento o se considera que tiene tal impedimento.

"Impedimento físico o mental" significa (a) cualquier condición o trastorno fisiológico, desfiguramiento cosmético o pérdida anatómica que afecta uno o más de los siguientes sistemas del cuerpo: neurológico; musculoesquelético; órganos de los sentidos especiales; respiratorio, incluidos órganos del habla; cardiovascular; reproductivo, digestivo, genitourinario; sanguíneo y linfático; de la piel; y endocrino; o (b) cualquier trastorno mental o psicológico, como retraso mental, síndrome orgánico cerebral, enfermedad mental o emocional y discapacidades específicas de aprendizaje.

"Actividades principales de la vida" incluyen, pero no se limitan a cuidar de uno mismo, realizar tareas manuales, ver, escuchar, comer, dormir, caminar, pararse, levantar, doblarse, hablar, respirar, aprender, leer, concentrarse, pensar, comunicar y trabajar.
"Tiene un historial de tal impedimento" se define como tener un historial de un impedimento físico o mental que limita sustancialmente una o más de las actividades principales de la vida, o haber sido clasificado (o mal clasificado) como que tiene tal impedimento.

(*Citas extraídas del artículo 504 de la Ley de Rehabilitación [Rehabilitation Act] de 1973 y de la Ley sobre Estadounidenses con Discapacidades [Americans with Disabilities Act] de 1990)

Federal Nondiscrimination Statement—Declaración de no discriminación de USDA— Page3 / Página 3

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

USDA Nondiscrimination Statement 2015 (Spanish Translation)

De conformidad con la Ley Federal de Derechos Civiles y los reglamentos y políticas de derechos civiles del Departamento de Agricultura de los EE. UU. (USDA, por sus siglas en inglés), se prohíbe que el USDA, sus agencias, oficinas, empleados e instituciones que participan o administran programas del USDA discriminen sobre la base de raza, color, nacionalidad, sexo, discapacidad, edad, o en represalia o venganza por actividades previas de derechos civiles en algún programa o actividad realizados o financiados por el USDA.

Las personas con discapacidades que necesiten medios alternativos para la comunicación de la información del programa (por ejemplo, sistema Braille, letras grandes, cintas de audio, lenguaje de señas americano, etc.), deben ponerse en contacto con la agencia (estatal o local) en la que solicitaron los beneficios. Las personas sordas, con dificultades de audición o discapacidades del habla pueden comunicarse con el USDA por medio del Federal Relay Service [Servicio Federal de Retransmisión] al (800) 877-8339. Además, la información del programa se puede proporcionar en otros idiomas.

Para presentar una denuncia de discriminación, complete el Formulario de Denuncia de Discriminación del Programa del USDA, (AD-3027) que está disponible en línea en: http://www.ocio.usda.gov/sites/default/files/docs/2012/Spanish_Form_508_Compliant_6_8_12_0.pdf. y en cualquier oficina del USDA, o bien escriba una carta dirigida al USDA e incluya en la carta toda la información solicitada en el formulario. Para solicitar una copia del formulario de denuncia, llame al (866) 632-9992. Haga llegar su formulario lleno o carta al USDA por:

(1) correo: 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; o

(3) correo electrónico: program.intake@usda.gov.

Esta institución es un proveedor que ofrece igualdad de oportunidades.