

INTEROFFICE CORRESPONDENCE

Los Angeles Unified School District

TO: Parent/Guardian **DATE:** August 17, 2020
FROM: Food Services Division
SUBJECT: Special Meal and Milk Substitution Requests ***During Distance Learning***

During Distance Learning, you may request a special meal for a student. The meal pick-up site may be different from the school your student would normally attend during this time.

Once special diet forms are turned in to Food Services, you will be contacted about when the special diet meals start and what school to pick them up from. Below are the different special diet requests and how to request them:

1. **First-Time Special Meal Requests or Prior Meal Requests with Changes:**
 Completes Section A of the *LAUSD Medical Statement to Request Special Meals* (Special Meal Request Form) on page 2. ***Give the form to a doctor to do section C.***
2. **Renewing Last Year’s Special Meal Request:**
 - A. **No changes** to your child’s special diet from last year, then renew the diet by emailing or texting the Nutrition Specialist assigned to the district where meals will be picked up from (see table at the bottom of this page).
 - B. **Changes** to last year’s special diet, then **complete a new form** on page 2 and ***give the form to a doctor to do section C.***
3. **Milk Substitution:**
 - A. **Almond or Rice Milk, or Juice** – if needed complete the Special Meal Request Form on page 2 and ***give the form to a doctor to do section C.***
 - B. **Soy Milk** – if needed, complete the *Parental Request to Substitute Soy Milk for Fluid Milk* (Soy Milk Request Form) on page 4. **Only parent/guardian signature is needed.**
 - C. **Lactose-Free Milk** – **No form needed** to get this. Ask the person handing out meals for the milk.
4. **Turning In Completed Special Diet Request Form or Soy Milk Request Form:**
 - A. Scan and email or take a photo and text completed forms to the Nutrition Specialist assigned to the district where meals are picked up from.
 - B. If you cannot email or text the form to a Nutrition Specialist, then give it to the Food Service Manager at the school closest to your home.

NUTRITION SPECIALIST CONTACT INFORMATION			
District	Nutrition Specialist	Email	Phone
Northeast, Northwest	Kim Nguyen	duyen.nguyen@lausd.net	213-503-6772
Central, East	Homa Hashemi	homa.hashemi@lausd.net	213-703-6296
South, West	Ivy Marx	ivy.marx@lausd.net	213-392-7129

**2020/2021 LAUSD MEDICAL STATEMENT TO REQUEST SPECIAL MEALS
FOR MEALS PICKED UP FROM SCHOOL SITE – DISTANCE LEARNING**

A. Parent/Guardian: Complete the following (1 - 9)		
1. Student Last Name (<i>Apellido</i>)	2. Student First Name (<i>Nombre del estudiante</i>)	3. Date of Birth (<i>Fecha de nacimiento</i>)
4. Parent/Guardian Name (<i>Nombre Impreso de los padres/tutores</i>)	5. Parent/Guardian Phone # (<i>Número(s) de teléfono del los padres/tutores</i>): Cell(<i>Celular</i>)(____)____ - _____ Home(<i>Casa</i>)(____)____ - _____ Email Address (<i>Correo Electrónico</i>):	
6. Parent/Guardian Signature (<i>Firma de los padres/tutores</i>)	7. Meals Requested for Pick-Up (<i>Marque las comidas que quieres recoger</i>) <input type="checkbox"/> Breakfast (<i>Desayuno</i>) <input type="checkbox"/> Lunch (<i>Almuerzo</i>) <input type="checkbox"/> Supper (<i>Cena</i>)	
8. Name of School that Meals Will Be Picked Up From (<i>Nombre de la escuela de la que recogerá las comidas</i>)	9. Name of School Your Child Would Normally Attend if Different From #7 (<i>Nombre de la escuela a la que normalmente asistiría su hijo si es diferente del #7</i>)	

B. Food Services Manager (FSM): Complete the following (10 - 19)			
10. School Name	11. Cafeteria Phone No.	12. Loc.Code	13. District
			14. Kitchen Type <input type="checkbox"/> PREP <input type="checkbox"/> NNC
15. LAUSD Student ID Number: (<i>ID has ten characters</i>)			ID Number not available for EEC students
16. FSM Name	17. FSM Email @lausd.net	18. Cafeteria Phone # ()	19. Is this an EEC Student? <input type="checkbox"/> YES <input type="checkbox"/> NO

C. State Licensed Healthcare Professional (Licensed Physician, Physician Assistant, Nurse Practitioner): Complete boxes 20 - 32.	
20. Description of Child's Physical or Mental Impairment Affected: (<i>Describe how the physical or mental impairment restricts the child's diet</i>)	
21. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation: (<i>Describe a specific diet or accommodation that has been prescribed</i>)	
22. Indicate Special Texture if Needed: <input type="checkbox"/> Ground <input type="checkbox"/> Pureed <input type="checkbox"/> Chopped Finely <input type="checkbox"/> Chopped Dime-Sized <input type="checkbox"/> Chopped Nickel-Sized <input type="checkbox"/> Chopped Quarter-Sized	
23. Foods to be Omitted and Substitutions (<i>List specific foods to be omitted and specific foods to include. Attach separate sheet if needed</i>)	
A. Foods to be Omitted (<i>Specific Foods to Omit</i>)	B. Suggested Substitutions (<i>Specific Foods to Include</i>)
_____	_____
_____	_____
24. Adaptive equipment to be used (<i>If applicable, describe specific equipment required to assist child with dining</i>):	
25. & 26: Complete ONLY if applicable for students with dairy or egg allergy or intolerance	25. Milk/Dairy Allergy or Intolerance: This student is NOT able to eat/drink the following (check off all that apply): <input type="checkbox"/> Fluid Cow's Milk <input type="checkbox"/> Lactose Free Cow's Milk <input type="checkbox"/> Baked Goods containing Milk/Dairy products <input type="checkbox"/> Yogurt <input type="checkbox"/> Cheese <input type="checkbox"/> Condiments containing Milk/Dairy products
	26. Egg Allergy or Intolerance: This student is NOT able to eat the following (check off all that apply): <input type="checkbox"/> Scrambled Eggs/Egg Patties <input type="checkbox"/> Condiments containing eggs (<i>mayonnaise, salad dressings, etc.</i>) <input type="checkbox"/> Baked Goods containing eggs <input type="checkbox"/> Foods containing eggs as a minor ingredient
27. Name of State Licensed Healthcare Professional:	28. Signature of State Licensed Healthcare Professional:
29. Date:	
30. Check One: <input type="checkbox"/> MD/DO <input type="checkbox"/> PA <input type="checkbox"/> Nurse Practitioner	31. Healthcare Professional's Phone #: (____) _____ - _____
32. Name/Phone # of Registered Dietitian following student (<i>if applicable</i>):	

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 mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410; fax (202) 690-7442 or e-mail: program.intake@usda.gov. This institution is an equal opportunity provider.

INSTRUCTIONS FOR LAUSD MEDICAL STATEMENT TO REQUEST SPECIAL MEALS

FOR MEALS PICKED UP FROM SCHOOL SITE – DISTANCE LEARNING

1. Parent/Guardian completes Section “A”.
2. Food Service Manager (FSM) completes Section “B”.
3. Healthcare Professional completes Section “C”.
4. **Incomplete request forms will not be processed.** All fields of the form must be filled in.
5. Parent/Guardian emails or texts the completed form to the Nutrition Specialist. If this is not possible, submit form to the FSM at the school you will be picking up meals from.
6. FSM sends the completed form to the Nutrition Specialist (NS).
7. NS processes the request and emails special diet guidelines to the FSM and parent/guardian.
8. FSM keeps the special diet on file and gives a copy to the school nurse, and Section 504 coordinator.
9. Special meals are not provided to accommodate food preferences or religious convictions.
10. Visit the LAUSD website at <http://cafe-la.lausd.net> to view and/or print the monthly menu, *Food Allergen and Ingredient List*, *Nutrient Analysis* or *Carbohydrate Count*.

IMPORTANT POINTS REGARDING SECTION C FOR THE HEALTH CARE PROFESSIONAL:

- The State Licensed Healthcare Professional signing this form must complete all boxes under Section C; however, boxes 25 and 26 are only required if the student has a dairy or egg allergy or intolerance.
- **Specific details are required for items 20 and 21.** Additional pages may be attached to this form if necessary.
- If all sections are not complete, the form will be returned, and **the special diet will not be processed.**
- A state licensed healthcare professional in California is a **Licensed Physician, Physician Assistant or Nurse Practitioner.**

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and the 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.

**LOS ANGELES UNIFIED SCHOOL DISTRICT FOOD SERVICES DIVISION
Parental Request to Substitute Soy Milk for Fluid Milk**

FOR MEALS PICKED UP AT SCHOOL SITE – DISTANCE LEARNING

Parent/Guardian may request soy milk for their child as a substitute for cow's milk due to medical or other special dietary need. A healthcare professional's signature is **not** required.

1. Parent/Guardian Instructions:

- A. Complete boxes 1 - 5 and 14 -20; and read information in box 13.
- B. Scan and email or take a photo and text completed forms to the Nutrition Specialist assigned to the district where meals are picked up from.
- C. If you cannot email or text the form to a Nutrition Specialist, then give to the Food Service Manager at the school closest to your home.

2. Food Service Manager Instructions (to be completed when received by Nutrition Specialist):

- A. Complete boxes 6-12.
- B. Email the Student ID Number of the student to your Nutrition Specialist
- C. Keep the completed form on file in the school cafeteria office.

PARENT/GUARDIAN REQUEST TO SUBSTITUTE SOY MILK FOR FLUID MILK		
1. Student Last Name	2. Student First Name	3. Date of Birth
4. Name of School that Meals Will Be Picked Up From	5. Name of School Your Child Would Normally Attend if Different From #7	
6. Student ID Number (has 10 characters) <i>(Not available for EEC Students)</i> _____		
7. School Name (Include EEC, if applicable)	8. Location Code	9. District
10. Food Services Manager Name	11. Food Services Manager Email _____@lausd.net	12. Cafeteria Phone No. ()
13. Guidelines for using this form: <ul style="list-style-type: none"> The above listed student does not have a disability but is requesting soy milk as a substitute for liquid milk due to a medical or other special dietary need. This form is not intended to accommodate students who drink soy milk due to taste preferences. Food Services has the discretion to select a specific brand of milk substitute to must meet specified nutrient requirements. Juice cannot be offered as a fluid milk substitute for students with medical or special dietary needs that do not rise to the level of a disability. This written statement will remain in effect until the parent or legal guardian cancels such statement or until the school discontinues the fluid milk substitution option. 		
14. Medical or other special dietary need requiring soy milk to substitute for fluid milk:		
15. Print Parent/Guardian Name	16. Parent/Guardian Signature	17. Date
18. Parent/Guardian Contact Information Home No. () _____ - _____	19. Cell No. () _____ - _____	20. Email Address:

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 mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.