

# INTEROFFICE CORRESPONDENCE

## Los Angeles Unified School District

**TO:** Food Services Manager (FSM)

**DATE:** May 8, 2018

**FROM:** Food Services Division

**SUBJECT:** Procedure for Requesting Special Meals and Fluid Milk Substitutions

### NEW for 2018/2019!

- **Previously Submitted Special Meal Requests:** If a Special Meal Request was submitted for the 2017/2018 school year and there are no changes to the diet prescription, the 2017/2018 form can be honored for the 2018/2019 school year.

The following steps must be taken if a previously submitted form will be used for 2018/2019:

1. The parent/guardian will sign and date the previously submitted form.
  2. The Food Service Manager will send it to their assigned Nutrition Specialist.
  3. The Nutrition Specialist will provide special diet instructions for the 2018/2019 school year.
- **Newman Nutrition Sites:** Effective August 2018, the FSM is responsible for ordering the Grocery (Foods Warehouse) and Dairy (Driftwood) items for special diets. The Newman Nutrition Center will no longer provide these items.
  - **Discontinued Special Diets:** The USDA has recommended that a student's parent/guardian provide a written statement when a special diet is discontinued. Attached to this memo is a simple form the parent/guardian can complete. Completed forms are to be sent to the Nutrition Specialist assigned to your school.

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### General Procedures

1. The Food Service Manager (FSM) will provide the **2018/2019 LAUSD Medical Statement to Request Special Meal Form (rev. 5/2018)** to the parent/guardian requesting a special diet and will review the form and answer questions as needed.
2. The FSM will receive the completed forms. The FSM must check the forms for the following:
  - ✓ All sections of the form are completed.
  - ✓ The form is signed by a State Licensed Physician, Physician Assistant or Nurse Practitioner.

**IMPORTANT: Special Note to FSM** – During the 2017/2018 school year, many special diet forms were received with incomplete school information (Section B). It is very important that the FSM complete Section B before sending the form to the Nutrition Specialist. Incomplete forms cause a delay in providing special diets in a timely manner.
3. If a written medical statement is submitted, the **Student, Parent, and School Information** must be attached.
4. **Incomplete forms/statements submitted to the Nutrition Specialist will be returned to the FSM.**

## **General Procedures (continued)**

5. Completed original forms are to be filed in the Cafeteria. **Scan** and **email** the completed forms/statement to your Nutrition Specialist:

District	Nutrition Specialist	Email	Phone
Northwest & Northeast	Stephanie Marks	<a href="mailto:stephanie.marks@lausd.net">stephanie.marks@lausd.net</a>	213-241-2994
Central & East	Homa Hashemi	<a href="mailto:homa.hashemi@lausd.net">homa.hashemi@lausd.net</a>	213-241-2969
West & South	Lynn Uusitalo	<a href="mailto:lynn.uusitalo@lausd.net">lynn.uusitalo@lausd.net</a>	213-241-3037

6. Completed forms/statements will be reviewed and processed by the Nutrition Specialist. The FSM will receive (via email) an approved diet or will be informed why a request could not be fulfilled.
7. The FSM must provide a copy of the special diet information to the **Parent/Guardian, School Nurse, and Section 504 Coordinator.**
8. The FSM is responsible for ordering and providing all special meals including Newman Nutrition Center meals.

## **Fluid Milk Substitutions for Students Participating in LAUSD School Meal Programs**

Fluid Milk Substitutes	How to Request
<ul style="list-style-type: none"><li>• Almond Milk</li><li>• Rice Milk</li><li>• Juice</li><li>• Soy Milk</li></ul>	<p>Complete the <i>2018/2019 LAUSD Medical Statement to Request Special Meals (rev. 5/2018)</i>. The Healthcare Professional must specify the milk or juice substitute requested on the form in Section 18, "Suggested Substitutions".</p> <p style="text-align: center;"><b><u>OR</u></b></p> <p>Provide a written medical statement from a State licensed Health Care Profession (Physician, Physician Assistant or Nurse Practitioner). The written statement must specify the milk or juice substitute being requested.</p> <p><b><u>Soy Milk:</u></b> If soy milk is the only accommodation needed, the parent/guardian can complete the "Parent/Guardian Request to Substitute Soy Milk for Fluid Milk" form. This form does <u>not</u> require a signature from a Healthcare Professional.</p>

# 2018/2019 LAUSD MEDICAL STATEMENT TO REQUEST SPECIAL MEALS (rev. 5/2018)

<b>A. Parent/Guardian: Complete the following (1-6)</b>			
<b>1. Student Last Name</b> ( <i>Apellido</i> )		<b>2. Student First Name</b> ( <i>Nombre del estudiante</i> )	
<b>3. Date of Birth</b> ( <i>Fecha de nacimiento</i> )			
<b>4. Parent/Guardian Name</b> ( <i>Escriba en letra de molde el nombre del padres</i> )		<b>5. Parent/Guardian Phone #</b> ( <i>Numero(s) de teléfono del padres</i> ):	
		Home (Casa): (    )	Cell (Celular): (    )
		Email Address ( <i>Correo Electrónico</i> ):	
<b>6. Meals Eaten At School</b> ( <i>Marque las comidas que su niño/a come en la escuela</i> )			
<input type="checkbox"/> <b>Breakfast</b> ( <i>Desayuno</i> ) <input type="checkbox"/> <b>Lunch</b> ( <i>Amuerzo</i> ) <input type="checkbox"/> <b>Snack</b> ( <i>Bocadillo</i> ) <input type="checkbox"/> <b>Supper</b> ( <i>Cena</i> )			

<b>B. Food Services Manager (FSM): Complete the following (7-14)</b>			
<b>7. School Name</b>		<b>8. Loc. Code #</b>	<b>9. District</b>
			<b>10. School Phone #</b> (    )
<b>11. Kitchen Type</b> <input type="checkbox"/> Prep <input type="checkbox"/> NNC	<b>12. FSM Name</b>	<b>13. FSM Email</b> _____@lausd.net	<b>14. Cafeteria Phone #</b> (    )

<b>C. Healthcare Professional (Licensed Physician, Physician Assistant or Nurse Practitioner): Complete the following (15-27).</b> (NOTE: ALL SECTIONS <u>MUST</u> BE COMPLETED BEFORE A MODIFIED MEAL CAN BE PROVIDED.)	
<b>15. Description of Child's Physical or Mental Impairment Affected:</b> ( <i>Describe how the physical or mental impairment restricts the child's diet</i> )	
_____ _____ _____	
<b>16. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:</b> ( <i>Describe a specific diet or accommodation that has been prescribed</i> )	
_____ _____ _____	

<b>17. Indicate Texture:</b>	
<input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed	
<b>18. Foods to be Omitted and Substitutions</b> ( <i>List specific foods to be omitted and specific foods to include. Attach separate sheet if needed</i> )	
<b>A. Foods to be Omitted (Specific Foods to Omit)</b>	<b>B. Suggested Substitutions (Specific Foods to Include)</b>
_____	_____
_____	_____
_____	_____
_____	_____

<b>19. Adaptive equipment to be used</b> ( <i>If applicable, describe specific equipment required to assist child with dining</i> ):		
<b>20. &amp; 21:</b> Complete these sections <u>only</u> if applicable to this student.	<b>20. Milk/Dairy Allergy or Intolerance: This student is <u>NOT</u> able to eat/drink the following (check off all that apply):</b>	
	<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	
	<b>21. Egg Allergy or Intolerance: This student is <u>NOT</u> able to eat the following (check off all that apply):</b>	
<input type="checkbox"/> Scrambled Eggs/Egg Patties <input type="checkbox"/> Baked Goods containing eggs <input type="checkbox"/> Condiments containing eggs ( <i>mayonnaise, salad dressings, etc.</i> )		
<b>22. Name of State Licensed Healthcare Professional:</b>		<b>23. Signature of State Licensed Healthcare Professional:</b>
<b>24. Check One:</b> <input type="checkbox"/> MD/DO <input type="checkbox"/> PA <input type="checkbox"/> Nurse Practitioner		<b>25. Healthcare Professional's Phone #:</b> (    )
<b>26. Date:</b>		
<b>27. Name/Phone # of Registered Dietitian following student</b> ( <i>if applicable</i> ):		

## **INSTRUCTIONS FOR 2018/2019 LAUSD MEDICAL STATEMENT TO REQUEST SPECIAL MEALS (REV. 5/2018)**

1. Parent/Guardian completes Section "A".
2. Food Service Manager (FSM) completes Section "B".
3. State Licensed Healthcare Professional completes Section "C".
4. **Incomplete request forms will not be processed.** All fields of the form must be filled in.
5. Submit the completed form to the FSM. The FSM will send the completed form to the Nutrition Specialist (NS). The NS will process the request and send the special diet to the FSM. The FSM will keep the special diet on file and give a copy to the parent/guardian, school nurse, and Section 504 coordinator.
6. Special meals are not provided to accommodate food preferences or religious convictions.
7. You may visit the LAUSD website at <http://cafe-la.lausd.net> and print the monthly menu, "Food Allergen and Ingredient List", "Nutrient Analysis" and "Carbohydrate Count".

### **Lactose-Free Fluid Milk**

Lactose-free fluid milk is offered as part of the reimbursable meal. No form is required.

### **IMPORTANT NOTES:**

- The State Licensed Healthcare Professional signing this form must complete all lines in Section C. **A detailed narrative is required for questions number 15 and 16.** Additional pages may be attached to this form if necessary. **If all sections are not complete, the form will be returned.**
- For the purpose of this form, 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.

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**LOS ANGELES UNIFIED SCHOOL DISTRICT  
FOOD SERVICES DIVISION  
Parent/Guardian Statement to Discontinue a Special Diet  
2018/2019**

**Directions:**

1. The parent/guardian of a child who is currently receiving a special diet but no longer requires the special diet can complete this form to discontinue the diet.
2. Return the completed form to the Food Service Manager at your child's school.
3. The Food Service Manager will send the form to the Nutrition Specialist and the special diet will be discontinued.

**School:** \_\_\_\_\_

**Location Code:** \_\_\_\_\_

**Food Service Manager:** \_\_\_\_\_

**Name of Student:** \_\_\_\_\_  
(Nombre del estudiante)

**Date of Birth:** \_\_\_\_\_  
(Fecha de nacimiento)

**Parent/Guardian Statement:** *My child no longer requires a special diet. I would like him/her to receive meals from the standard menu.*

**Signature of Parent/Guardian:** \_\_\_\_\_  
(Escriba en letra de molde el nombre del padres)

**Date:** \_\_\_\_\_

**LOS ANGELES UNIFIED SCHOOL DISTRICT  
FOOD SERVICES DIVISION**

**Parental Request to Substitute Soy Milk for Fluid Milk**

1. Parents/Guardians may request soy milk for their child as a substitute for fluid cow's milk due to medical or other special dietary need. A medical authority signature is **not** required for this form.
2. Complete form below. Give the completed form to the Food Service Manager.
3. The Food Service Manager will keep the completed form on file in the school cafeteria office.

<b>PARENT/GUARDIAN REQUEST TO SUBSTITUTE SOY MILK FOR FLUID MILK</b>		
<b>1. Student Last Name</b>	<b>2. Student First Name</b>	<b>3. Date of Birth</b>
<b>4. School Name</b> <i>(Include EEC, if applicable)</i>	<b>5. Location Code</b>	<b>6. District</b>
<b>7. Food Services Manager Name</b>	<b>8. Food Services Manager Email</b> _____@lausd.net	<b>9. Cafeteria Phone No.</b> (     )
<p><b>10.</b> 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 fluid milk substitutions such as soy milk due to taste preferences. The School Food Authority has the discretion to select a specific brand of milk substitute since acceptable products must meet specified nutrient requirements. <b>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.</b></p> <p>This written statement will remain in effect until the parent or legal guardian revokes such statement or until the school discontinues the fluid milk substitution option. School Districts participating in federal nutrition programs are encouraged, but not required to accommodate reasonable requests.</p> <p><b>The student's parent or legal guardian must sign this form.</b></p>		
<b>11. Medical or other special dietary need requiring soy milk to substitute for fluid milk:</b>		
<b>12. Parent/Guardian Name</b>	<b>13. Parent/Guardian Signature</b>	
<b>14. Parent/Guardian Phone No.</b> (     )	<b>15. Date</b>	

**Please note: When necessary, the information on this form should be updated to reflect the current medical and/or nutritional needs of the student.**

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