



SHADY CREEK OUTDOOR SCHOOL & EVENTS

Billing and Reservations

970 Klamath Lane, Yuba City, CA 95993

Office: (530) 822-2949

Fax: (888) 847-1453

Camp Address

18601 Pathfinder Way, Nevada City, CA 95959

(530) 822-2470



Christopher Little, Shady Creek Director

Meal Accommodation's

Please fill out this form and return it to your school site to be sure your child's dietary needs are met. The attached document must accompany this cover sheet:

Child's Name: _____

School Attending With: _____

Dates Attending Shady Creek: _____

Parent Contact Information:

Cell Phone: _____

Work Phone: _____

Home Phone: _____

If you would like to speak to our kitchen staff regarding your child's dietary needs, they can be reached at:

Phone: (530) 822.2471

Email: KindyM@sutter.k12.ca.us

We will make every effort to meet your child's dietary needs in-house and prefer that parents not send food. If you must send food, it must be packed in a disposable Styrofoam ice chest or insulated bag that does not need to be returned. We cannot be responsible for items not being returned to the parents.

12. Adaptive Equipment to be Used:			
13. Signature of State Licensed Healthcare Professional*	14. Printed Name	15. Phone Number	16. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

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.

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served.
3. **Site Phone Number:** Print the phone number of site where meal will be served.
4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.
5. **Age of Child or Participant:** Print the age of the child or participant. For infants, please use date of birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.
7. **Phone Number:** Print the phone number of parent or guardian.
8. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.
9. **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.

10. **Indicate Texture:** If the child or participant does not need any modification, check “Regular”.
11. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).
12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).
13. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.
14. **Printed Name:** Print name of state licensed healthcare professional.
15. **Phone Number:** Phone number of state licensed healthcare professional.
16. **Date:** Date state licensed healthcare professional signed form.

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.