Special Diet Statement

School Food Authorities (SFAs) must make reasonable substitutions to meals on a case-by-case basis for children who are considered to have a disability that restricts their diet [7 CFR 210.10(m)]. According to the ADA Amendments Act, most physical and mental impairments will constitute a disability.

SFAs are not required to accommodate special dietary requests that do not constitute a disability, including requests related to religious or moral convictions or personal preference. If these requests are accommodated, SFAs must ensure all USDA meal pattern and nutrient requirements are met.

This form is to be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. Updates to this form are required only when a child’s needs change.

Note: Parents may provide a written request for lactose-reduced milk if their child is lactose intolerant without a physician’s signature.

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 this food affects the child: __________________________________

3. List specific foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

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<th>Foods to be Omitted</th>
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Additional Information

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

☐ Tube Feeding

Formula Name: ____________________________________________________________

Administering Instructions: ________________________________________________

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: ______________________________________
**Signature**

Licensed physician, physician assistant, 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 Parent(s)/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 (HIPPA) 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): ___________________________________________

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.