

Special Diet Statement

Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make accommodations to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet: School Nutrition Program – 7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4). According to the ADA Amendments Act, most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.

Sponsors 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, sponsors must ensure that all USDA meal pattern and nutrient requirements are met.

This form must 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 participant's needs change.

Note to Districts/Schools: Parents/Guardians may provide a written request for lactose-reduced milk without a physician's signature.

Submit this completed special diet statement to: _____

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 participant:

3. List specific foods to be omitted and substituted, if appropriate. Attach additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

Additional Information

Texture Modification: Pureed Ground Bite-Sized Pieces Other: _____

Tube Feeding Formula Name: _____

Administering Instructions: _____

Oral Feeding: No Yes If yes, specify foods: _____

Other Dietary Modifications or Additional Instructions (describe): _____

Signature

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and return 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 (HIPAA) 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): _____