# 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:** SFAs must make lactose-reduced milk available to a student if they receive written notice from the parent that the child is lactose intolerant [MN State Statute 124D.114 (a)].

## Participant Information

Participant's Name: Last/First/Middle Initial _____ Today's Date _____

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.

| Foods to be Omitted | Foods to be Substituted |
|---|---|
| | |
| | |
| | |
| | |

## Additional Information:

☐ **Texture Modification**: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other (specify):_____

☐ **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

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