

# Special Diet Statement

## Why am I being asked to fill out this form?

Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet.\* 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 are not a disability. This includes 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-free milk without a physician's signature. Lactose-free milk served must meet meal pattern requirements for the program.

Submit this completed special diet statement to: \_\_\_\_\_

## Participant Information:

Participant's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of School/Center/Site Attended: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

## Required Information: Dietary Accommodation

1. List the food to be avoided:  
\_\_\_\_\_
2. Briefly explain how exposure to this food affects the participant:  
\_\_\_\_\_
3. List 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: \_\_\_\_\_

Tube Feeding Formula Name: \_\_\_\_\_

Administering Instructions: \_\_\_\_\_

Oral Feeding:  No  Yes If yes, specify foods: \_\_\_\_\_

Other Dietary Modification or Additional Instructions (Describe): \_\_\_\_\_

## Required Signature

This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner. The medical person signing it should keep a copy of this document in his/her records.

Prescribing Authority Credentials (print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Clinic/Hospital: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Voluntary Authorization

**Note to Parent(s)/Guardian(s)/Participant: You may allow the director of the school/center/site to talk with the medical person about this Special Diet Statement by signing the 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 ONLY): \_\_\_\_\_

## Non-Discrimination Statement

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](#) ([http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](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](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.