**Hancock School ISD #768**

**Special Diet Statement**

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: 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. However, please note - almond milk does not meet the USDA criteria for a milk substitution and will not be provided by the school.

# 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Brief explanation of how exposure to this food affects the participant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |
| --- | --- | --- |
| **Foods to be Omitted**  |  | **Foods to be Substituted**  |
| NA  | NA  |  |
| NA  | NA  |  |
| NA  | NA  |  |

# 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

1. fax: (202) 690-7442; or
2. email: program.intake@usda.gov

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