SPECIAL DIET STATEMENT
For a Participant *With* a Disability

This Special Diet Statement is ONLY for a participant *with* a disability that affects the diet. This form must be:

- Thoroughly completed and signed by a licensed physician.
- Submitted to the school/center/site before any meal modifications will be made in the United States Department of Agriculture Child Nutrition Programs.
- Updated whenever the participant's diagnosis or special diet changes.

PART 1: PARTICIPANT INFORMATION
PARENT OR GUARDIAN MUST COMPLETE. PLEASE PRINT.

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:

Parent /Guardian Address:	City:	State:	Zip Code:

Meals or snacks to be eaten at school/center/site: (check all that apply)

School:	**Center / Child Care / Adult Care Center:**	**Site–Summer Food Service Program:**
☐ Breakfast ☐ Lunch	☐ Breakfast ☐ Lunch ☐ Supper	☐ Breakfast ☐ Lunch ☐ Supper
☐ Afterschool Care Program (snack)	☐ am / pm / eve Snack ☐ Afterschool Snack	☐ Snack

Parent/Guardian Signature: _____ Date: _____
OR Participant's Signature (Adult Day Care)

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 Voluntary Authorization section at the end of this form.

PART 2: PARTICIPANT STATUS
LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT.

Participant has a disability and requires a special diet or food accommodation.

An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the American with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits one or more major life activities.

Refer to the document titled *Special Diet Statement Guidance* for definitions of "disability" and "major life activities" which is included with this form.

1. Identify the participant's disability: **and/or**

Identify food allergy that is life-threatening / anaphylactic (considered a disability):

2. Identify the "major life activities" affected by the disability:

3. Describe how the disability restricts the participant's diet:

PART 3: DIETARY ACCOMMODATION
FOODS TO BE OMITTED AND FOODS TO BE SUBSTITUTED / OTHER INSTRUCTIONS
LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT

Foods to be omitted and substitutions: List specific foods to be omitted **and** foods to be substituted. You may attach a sheet with additional information.

FOODS TO BE OMITTED	FOODS TO BE SUBSTITUTED

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

☐ **Tube Feeding:** Formula Name: _____

Administering Instructions: _____
Oral Feeding: ☐ No ☐ Yes If Yes, specify foods: _____

☐ **Other Dietary Modification OR Additional Instructions** (describe): _____

_____ (attach *specific diet order instructions)*

☐ **Infant Feeding Instructions** (if applicable):

SIGNATURE OF LICENSED PHYSICIAN

LICENSED PHYSICIAN MUST SIGN and RETAIN A COPY of this DOCUMENT.

Licensed Physician Name/Credentials (print): _____

Signature: _____ Date: _____

Clinic/Hospital Name: _____

Phone #: _____ Fax #: _____

VOLUNTARY AUTHORIZATION

A PARENT/GUARDIAN/PARTICIPANT MAY CHOOSE TO COMPLETE THIS SECTION GIVING PERMISSION TO THE LICENSED PHYSICIAN TO DISCUSS AND CLARIFY A DIET ORDER WITH A DIRECTOR OF A SCHOOL, CENTER OR SITE.

Note to Parent(s)/Guardian(s)/Participant: As stipulated in FNS Instruction 783, Rev. 2, Section V Cooperation: "When implementing the guidelines of this instruction, food service personnel should work closely with the parent(s)/guardian(s)/participant or responsible family member(s) and with all other medical and community personnel who are responsible for the health, well-being and education of a participant with a disability that affects the diet to ensure that reasonable accommodations are made to allow the individual's participation in the meal service.

This voluntary authorization encourages such cooperation by allowing the following:

- After review of this Special Diet Statement, the school, center or site may need more information or clarification from the physician before it can provide the special diet. By signing this authorization your are permitting the school, center or site to discuss or clarify the diet order with the physician.
- Before any changes agreed to between the director of the school, center or site and physician take place, the parent(s)/guardian(s)/participant need to be informed.
- The changes agreed to will then be incorporated into an amended Special Diet Statement.
- If more information is needed but this authorization statement has not been signed, implementation of the special diet may be delayed.
- If authorization is signed, make a copy of this document before submitting to the school, center or site.

This authorizes the licensed physician to discuss or clarify the diet order prescribed for _____ (participant's name) with the director at _____(name of school/center/site). This authorization will remain in effect until the diagnosis has changed or a new diet order is prescribed.

This authorization may be revoked at any time by submitting a request in writing to the physician who originally signed the Special Diet Statement.

I understand that specific information disclosed pursuant to this authorization may be subject to re-disclosure by the school/center/site director and will no longer be protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

Parent/Guardian Signature: _____ Date: _____
OR Participant's Signature (Adult Day Care)