Special Diet Accommodation Form

Why am I being asked to complete 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.

Part A: To be completed by parent/guardian

Student's full name:	Student's birthdate:
Parent/Guardian Name:	
Phone #:	Email address:

VOLUNTARY AUTHORIZATION:

Note to parent(s)/guardian(s)/participant: You may allow the director of the school to talk with the medical authority about this Special Diet statement by signing the Voluntary Authorization section below:

IN ACCORDANCE WITH THE PROVISIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996 AND THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA), I HEREBY AUTHORIZE _____ (NAME OF CHILD'S RECOGNIZED MEDICAL AUTHORITY) **TO RELEASE SUCH PROTECTED HEALTH INFORMATION OF MY CHILD AS IS NECESSARY FOR THE SPECIFIC PURPOSE OF SPECIAL DIET INFORMATION TO** _____ (NAME OF SCHOOL DISTRICT) **AND I CONSENT TO ALLOW THE RECOGNIZED MEDICAL AUTHORITY TO FREELY EXCHANGE THE INFORMATION LISTED ON THIS FORM AND IN MY CHILD'S RECORDS WITH THE SCHOOL DISTRICT 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 MY CHILD. I UNDERSTAND THAT I MAY RESCIND PERMISSION TO RELEASE THIS INFORMATION AT ANY TIME, EXCEPT WHEN THE INFORMATION HAS ALREADY BEEN RELEASED.**

Signature of parent or guardian: _____ Date: _____

Part B: To be completed by authorized professional

Please complete the section below on child's special dietary requirements. Be specific as possible and please attach any additional instructions on a separate sheet as applicable.

1) State the physical or mental condition/impairment(s) that affects student's diet (required):

1) Describe how the physical or mental condition/impairment(s) listed restricts the student's diet (required):

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

Foods to be Omitted	**Foods to be Substituted** (Avoid specific brand names if possible)

Additional Modifications (complete as applicable)

Texture Modification (if applicable):
List foods that need the following change in texture. If all foods to be prepared in this manner, indicate "all"

Pureed:

Ground:

Chopped/cut up into bite size pieces:

Liquid Consistency (if applicable):
☐ Pudding Thick ☐ Honey Thick ☐ Nectar Thick ☐ Other (Please describe):

Adaptive Equipment (if applicable):
List any special equipment or utensils that are needed:

Additional instructions/comments:

REQUIRED SIGNATURE:

This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse. The medical authority should retain a copy of this document for their records.

Prescribing Authority Name & Credentials (print): _____

Signature: _____ Date: _____

Office/Clinic/Hospital Name: _____

Phone Number: _____ Fax Number: _____

USDA Non-discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. fax:
(833) 256-1665 or (202) 690-7442; or
3. email:
Program.Intake@usda.gov

This institution is an equal opportunity provider.