When completed please return to Laura in food services @ laura.krausezastrow@mapsedu.org

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	☐ Breakfast	☐ Breakfast
☐ Lunch	☐ Lunch	☐ Lunch
☐ Afterschool Care Program	☐ Supper	☐ Supper
	☐ Snack (am/pm/eve)	☐ Snack
	☐ Afterschool Meal	

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 or affects one or more major life activities (i.e., eating, seeing, hearing) and/or major bodily functions (i.e., digestion, bowel, bladder, immune system, respiratory, endocrine, etc.). **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 Number:______________________________ Fax Number:______________________

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

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 you 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)

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.