Health Services Request Form – C Special Diet/Food Intolerance/Allergy Action Plan

Place Child's Picture Here

Please keep a copy of the completed form for your records.

Part A – Participant, Parent/Guardian, and School/Agency Contact Information – To be completed by a parent/guardian or school/agency contact person –

1. School Name	**3. School Phone #**
4. Name of Participant (Student)	**5. Date of Birth**
6. Name of Parent/Guardian	**7. Parent/Guardian Phone #**
8. Parent/Guardian Address	

☐ *I understand that it is my responsibility to submit a new form annually or if medical changes occur. I acknowledge Bishop O'Gorman Catholic Schools personnel have limited or no knowledge of administering health services, and it assumes no liability for administering health related services.*

Part B – Special Diet – To be completed by a medical authority as defined on page 5.

7. Check One:

☐ a. Participant has a **disability**.

☐ b. Participant has a food allergy/intolerance or other medical condition that does not rise to the level of a disability.

8. Specify the disability, food allergy/intolerance, or medical condition requiring a special meal or accommodation (use extra pages if needed):

9. If participant has a disability (see definition on page 5)**, provide a brief description of participant's major life activity** (see list on page 5) **affected by the disability** (e.g. allergy to peanuts affects ability to breathe)**:**

☐ Check if not applicable

10. Describe the TYPE OF SPECIAL DIET REQUIRED (e.g. low sodium, gluten-free, diabetic, etc.) Use extra pages if needed:

☐ Check if not applicable

11. Modified Texture:

☐ Not Applicable ☐ Chopped

☐ Ground ☐ Pureed

12. Modified Thickness:

☐ Not ☐ Applicable Nectar

☐ Honey ☐ Spoon or Pudding Thick

13. Special Feeding Equipment (large handled spoon, sippy cup, etc.)**:**

☐ Check if not applicable

14. Foods to be omitted and substituted: (List specific foods to be omitted and suggested substitutions. You may sign and attach a sheet with additional information as needed.)

☐ Check if not applicable

A. Foods To Be Omitted	**B. Food Allergy with Risk of Anaphylaxis**
Suggested Substitutions for A.	**Suggested Substitutions for B.**

IMPORTANT: For a participant who does not have a recognized disability, the only fluid milk substitutions allowed by USDA are: (1) lactose-free fluid cow's milk or (2) a non-dairy beverage with a nutrition profile equivalent to cow's milk as specified in federal regulations. Currently the only beverages meeting these specifications are certain brands of soy milk.

15. SYMPTOMS – (Check appropriate action/medication for each category of symptoms):

☐ Asthma ***(high risk for severe reaction)*** ☐ Other Medical Concerns: _____

Type of Symptom	**Give Checked Medication***	
If a food allergen has been ingested, but no symptoms:	☐**Epinephrine**	☐**Antihistamine**
Mouth: Itching, tingling, or swelling of lips tongue, mouth	☐**Epinephrine**	☐**Antihistamine**
Skin: Hives, itchy rash, swelling of the face or extremities	☐**Epinephrine**	☐**Antihistamine**
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐**Epinephrine**	☐**Antihistamine**
Throat*: Tightening of throat, hoarseness, hacking cough	☐**Epinephrine**	☐**Antihistamine**
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness	☐**Epinephrine**	☐**Antihistamine**
Lung*: Shortness of breath, repetitive coughing, wheezing	☐**Epinephrine**	☐**Antihistamine**
Other*:	☐**Epinephrine**	☐**Antihistamine**
If reaction is progressing (several of the above areas affected), give:	☐**Epinephrine**	☐**Antihistamine**

**** Potentially life threatening***

16. WHAT TO DO: Follow the directed medication and dosage prescribed by physician.

a) INJECT EPINEPHRINE IN THIGH USING: ☐ Epipen Jr (0.15 mg) ☐ Epipen (0.3 mg)

b) Antihistamine (include medication dose):_____

c) Other: give_____ **d)**

CALL 911 or RESCUE SQUAD (BEFORE CALLING CONTACTS)

e) CONTACT FAMILY EMERGENCY NUMBERS

f) COMMENTS/ADDITIONAL INSTRUCTIONS

I certify that the above-named child needs special meals prepared as described above because of the child's disability / diagnosis.

Only a physician licensed under SDCL 36-4 may sign the special diet prescription.

Medical Facility: _____

17. Signature of Preparer	**18. Printed Name**	**19. Telephone Number**	**20. Date**
21. Signature of Medical Authority	**22. Printed Name**	**23. Title**	

Part C – Parent/Guardian Permission – To be completed by a parent/guardian	
I give permission for school/agency personnel responsible for implementing my child's special diet to discuss my child's special dietary accommodations with any appropriate school/agency staff and to follow the special diet for my child's school/agency meals. I also give permission for my child's medical authority to further clarify the special diet on this form if requested to do so by school/agency personnel.	
24. Parent/Guardian Signature:	**25. Date:**

Part D – Request Substitution for Fluid Cow's Milk due to Lactose Intolerance, Allergy, Vegan Diet, Religious, Cultural, or Ethical Reasons – To be completed by parent/guardian.	
26. Instead of fluid cow's milk, please provide the individual named in Part A of this form with the following substitute (check ONE): ☐ Lactose-free cow's milk ☐ Non-dairy beverage with a nutrient profile equivalent to fluid cow's milk per federal regulations	
27. Parent/Guardian Signature:	**28. Date:**

The U.S. Department of Agriculture 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 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.

As stated above, all protected bases do not apply to all programs, the ***first six protected bases of race, color, national origin, age, disability and sex are the six protected bases for applicants and recipients of the Child Nutrition Programs.***

SPECIAL DIET FORM

Important! Select the applicable meal modification category from the three listed below. Then, carefully read and follow the procedures for that category. The school/agency will return incomplete Medical Statements to the parent/guardian. **It is recommended that you keep a copy of the completed form.** If you have any questions about this form, contact the school/agency.

Definitions: An 'agency' on USDA Child Nutrition Programs might be a school, child care center, adult day care center, child care home, sponsoring organization, or institution. A 'participant' on USDA Child Nutrition Programs would be a student, child, or adult (in a day care setting) who receives meals at an agency.

Note to Parent/Guardian/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.

1. <u>Special Diet Order</u> due to a disability:

- A school/agency is required to provide a special diet prescribed by a licensed physician to accommodate a participant's disability. See the 'Definition of Disability' on the back of this form.
- Part B of this form must be completed by a licensed physician (MD or DO).
- Parts A and C of this form must also be completed before the school/agency can provide a special diet.
- The special diet required for a disability will continue until a licensed physician requests that the modification be changed or stopped.
- It is strongly recommended that a licensed physician annually update the special diet order.

2. <u>Special Diet Request</u> due to a food allergy, food intolerance or other medical condition that does not rise to the level of a disability:

- A school/agency has the option to provide a special diet requested by a recognized medical authority due to a food allergy, food intolerance or other medical condition that does not rise to the level of a disability.
- Part B of this form must be completed by a medical authority who is a licensed physician (MD or DO), physician's assistant (PA), Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), Registered Dietitian (RD), and Licensed Nutritionist (LN).
- For questions about recognized medical authorities, contact the school/agency.
- Parts A and C of this form must also be completed before the school/agency can provide a requested special diet (determined on a case by case basis).
- If provided, the requested special diet will continue until a recognized medical authority requests that the modification be changed or stopped.
- It is strongly recommended that a recognized medical authority annually update the special diet request.

3. Substitution for fluid cow's milk due to lactose intolerance, allergy, vegan diet, religious, ethical, or cultural reasons:

- A school/agency has the option to make a substitution for fluid cow's milk that is requested by a parent/guardian, but is not prescribed by a medical authority.
- Parts A and D on this form must be completed before the school/agency can make a substitution for fluid cow's milk.
- If a school/agency chooses to provide such a substitution, they will continue until a parent/guardian requests that the substitution be changed or stopped.

42 USC § 12102 – DEFINITION OF DISABILITY

(1) Disability

The term "disability" means, with respect to an individual—

(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment (as described in paragraph (3)).

(2) Major life activities (A) In general

For purposes of paragraph (1), major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

(B) Major bodily functions

For purposes of paragraph (1), a major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

(3) Regarded as having such an impairment For purposes of paragraph (1)(C):

(A) An individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.

(B) Paragraph (1)(C) shall not apply to impairments that are transitory and minor. A transitory impairment is an impairment with an actual or expected duration of 6 months or less.

Definition of Recognized Medical Authority (per SDCL 36-2-2 and the Dietetics and Nutrition Practice Act, 3610B)

The State of South Dakota recognizes the following as medical authorities in relation to non-required **"Special Diet Requests:"**

Medical Doctors (MD)
Doctors of Osteopathy (DO) Physician
Assistants (PA)
Certified Nurse Practitioners (CNP)
Certified Nurse Midwives (CNM)
Registered Dietitians (RD)
Licensed Nutritionists (LN)

Student Name: _____ Allergen: _____

Nutritional Information - Limitations and Terms

Bishop O†Gorman Catholic Schools and its food service contractor, Lunchtime Solutions, Inc. (the contractor), are able to provide nutritional information to students, parents, faculty or staff of or school districts upon request. This information is limited, and is intended as a general guide to help individuals make choices for products and recipes that they choose from the menu. You may wish to utilize the services of a registered dietitian or healthcare provider if you are screening menus, recipes or individual products for a particular nutrient value, or for a food allergen. By requesting and receiving this information you agree that:

The contractor's nutritional analysis is based on the information provided by their suppliers; food manufacturers and distributors. The information provided by these manufacturers and distributors is reviewed regularly by the contractor and is believed to be as current and as accurate as possible.

The contractor's food service suppliers, both food manufacturers and or food service distributors, may change finished products or product ingredients without notice to their customers and food service operators. Those ingredient or product changes may significantly alter the nutritional values of recipes that we may serve. Variance in shop and kitchen conditions, as well as the use of substituted ingredients may affect the nutritional profile of the finished recipes.

Ingredients and food service finished product manufacturers routinely label products for allergens that are present. The information provided to you by the contractor is believed to be accurate based upon the supplier information at the time of the informational request. Because food suppliers to the contractor may change ingredients without notice, screening of products and or recipes for specific allergens including, but not limited to, peanuts, eggs, fish, shellfish, tree nuts such as walnuts and pecans, milk, wheat and soybeans, and their byproducts, may not be accurate.

Because of those variances outside of the control of Bishop O†Gorman Catholic Schools or its contractor, Lunchtime Solutions, Inc., neither Bishop O†Gorman Catholic Schools nor its contractor can guarantee nor shall be liable for the accuracy of nutritional information or allergen screening information that is provided.

The Bishop O†Gorman Catholic Schools does not warrant that the food served will be free of these allergens, as food suppliers of our contractor may change ingredients without notice. By signing this acknowledgement, you agree that you have read this agreement and that the information provided hereunder does not constitute a warranty that the nutritional information is completely accurate or that food served will be free of allergens.

I agree to the above limitations of the information provided to me by Bishop O†Gorman Catholic Schools.

Signature _____ Date: _____

Print Name: _____