SPECIAL DIET STATEMENT

For a Participant *with* a Disability

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

- Thoroughly completed and signed by a licensed physician.
- Submitted to the school 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/GUARDIAN MUST COMPLETE. PLEASE PRINT

Participant's Name: Last / First / Middle Initial			Today's Date
Name of School Attending			Date of Birth
Parent/Guardian Name:	Home Phone Number	Work/Cell Phone Number	
Parent/Guardian Address	City	State	Zip Code
Meals or Snacks to be eaten at school: (Circle all that apply)	**Breakfast**	**Lunch**	**Snack**
Parent/Guardian Signature OR Adult Student Signature: _____		Date: _____	

Note to Parent(s)/Guardian(s)/Participant: You may authorize the school 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 Americans 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 AN FOODS TO BE SUBSTITUTED / OTHER INSTRUCTIONS
LICESNSED PHYSICIAN MUST COMPLETE. PLEASE PRINT

List specific foods to be omitted and 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 Modifications OR Additional Instructions (describe):**

_____

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

SIGNATURE OF LICENSED PHYSICIAN LICENSED PHYSICIAN MUST SIGN AND RETAIN A COPY DOCUMENT

Licensed Physician Name/Credentials (print): _____

Licensed Physician Signature: _____ Date: _____

Clinic/Hospital Name: _____

Office Phone: _____ Office 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 THE SCHOOL.

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 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 to discuss or clarify the diet order with the physician.
- Before any changes agreed to between the school and physician takes 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 it to the school.

This authorizes the licensed physician to discuss or clarify the diet order prescribed for _____

Participant's Name

with the appropriate staff of the Waunakee Community School District.

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 and will no longer be protected under the Health Insurance Portability and Accountability Act 0f 1996 (HIPAA) Privacy Rule.

Parent/Guardian/Participant Signature: _____ Date: _____