Special Diet Statement

School Food Authorities (SFAs) must make reasonable substitutions to meals on a case-by-case basis for children who are considered to have a disability that restricts their diet [7 CFR 210.10(m)]. According to the ADA Amendments Act, most physical and mental impairments will constitute a disability.

SFAs are not required to accommodate special dietary requests that do not constitute a disability, including requests related to religious or moral convictions or personal preference. If these requests are accommodated, SFAs must ensure all USDA meal pattern and nutrient requirements are met.

This form is to 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 child's needs change.

Note: Parents may provide a written request for lactose-reduced milk if their child is lactose intolerant without a physician's signature.

Participant Information

Participant's Name: Last/First/Middle Initial

Today's Date

Name of School and Homeroom Teacher

Date of Birth

Parent/Guardian Name

Home Phone Number

Work Phone Number

REQUIRED Information: Dietary Accommodation

1. State the allergen or food to be avoided:

2. Brief explanation of how exposure to this food affects the child:

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

4. Does your student plan on eating school meals: Yes No

   If yes, you will be contacted by Orono Child Nutrition regarding menu planning.

Foods to be Omitted	Foods to be Substituted

Additional Information

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

Tube Feeding: Formula Name: Administering Instructions:
Oral Feeding: No Yes If yes, specify foods:

Signature

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain a copy of this document.

Prescribing Authority Credentials (print): Date:

Signature: Clinic/Hospital:

Phone Number: Fax Number:

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may authorize the Supervisor of Child Nutrition to clarify this Special Diet Statement with the physician by signing the following Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize ________________________________ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to Orono Schools, Department of Child Nutrition and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program 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 me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. Optional: My permission to release this information will expire on ____/____/________**(date)**. This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian:

Date:

This institution is an equal opportunity provider.

Schumann Elementary Health Office	Phone: (952) 449-8487	**Fax: (952) 449-8499**
Orono Intermediate School Health Office	Phone: (952) 449-8473	**Fax: (952) 449-8479**
Orono Middle School Health Office	Phone: (952) 449-8461	**Fax: (952) 449-8453**
Orono High School Health Office	Phone: (952) 449-8417	**Fax: (952) 449-8449**