Special Diet Requests

The Child Nutrition Department makes reasonable substitutions to meals on a case by case basis for children who are considered to have a disability that restricts their diet. According to the ADA Amendments Act, most physical and mental impairments will constitute a disability.

The Child Nutrition Department is not required to accommodate special dietary requests that do not constitute a disability, including requests related to religious or moral convictions or personal preference.

The Special Diet Request Form is found on this page and can be submitted to the Child Nutrition Office at 401 N 44th Ave West, Rm 2407B, Duluth, MN 55807. You may also submit the completed form to the School Nurse. The department **must have** the "Special Diet Request Form" filled out by a licensed physician, physician assistant or certified nurse practitioner.

Milk Substitutions/Lactose Intolerance

The Child Nutrition Department is required by **MN Statute 124D.111** to provide lactose-reduced milk to students who are lactose intolerant and have a written request on file with the Child Nutrition Department. A doctor's signature **is not** required.

If you would like your child to receive lactose reduced milk, please submit a parent/guardian signed request to: Child Nutrition Department 401 N 44th Ave West, Rm 2407B, Duluth, MN 55802 or to the School Nurse.

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: _____Today's Date: _____
Last/First/Middle Initial

Name of School/Center/Site Attended: _____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.

Foods to be Omitted	Foods to be Substituted

Additional Information

☐ Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other: _____

☐ 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 director of the school/center/site 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 _____ **(program name)** 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: _____

OR Participant's Signature (Adult Day Care): _____