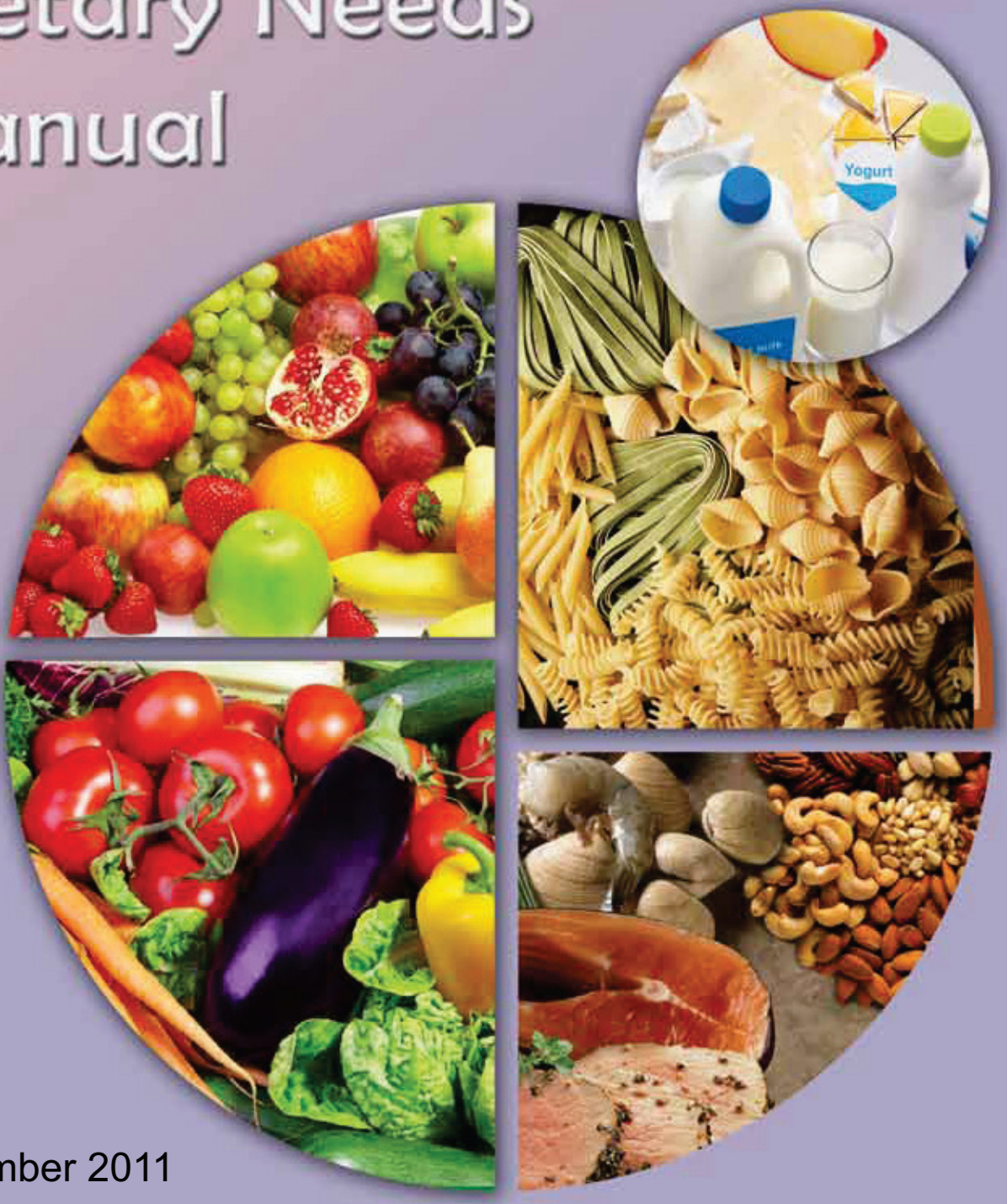
Arizona Department of Education

Special Dietary Needs Manual



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Health and Nutrition Services
School Health and Nutrition Programs

Arizona Department of Education

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SPECIAL DIET MANUAL

INTRODUCTION

In recent years, increased emphasis has been placed on the importance of ensuring that children with disabilities have the same opportunities as other children to receive an education and education-related benefits, such as school meals. Congress first addressed this concern in section 504 of ***The Rehabilitation Act of 1973***, which prohibits discrimination against qualified persons with disabilities in the programs or activities of any agency of the federal government's executive branch or any organization receiving federal financial assistance. For schools, these laws are enforced by the Office for Civil Rights (OCR) in the United States Department of Education.

Subsequently, Congress passed the ***Individuals with Disabilities Education Act (IDEA) of 1990*** which requires that a free and appropriate public education be provided for children with disabilities, who are three through 21 years in age, and the ***Americans with Disabilities Act (ADA) of 1990***, a comprehensive law which broadens and extends civil rights protections for Americans with disabilities. One effect of these laws has been an increase in the number of children with disabilities who are being educated in regular school programs. In some cases, the disability may prevent the child from eating meals prepared for the general school population. The U.S. Department of Agriculture's (USDA) nondiscrimination regulation (7 CFR 15 (b), as well as the regulations governing the National School Lunch Program and School Breakfast Program, make it clear that substitutions to the regular meal **MUST** be made for children who are unable to eat school meals because of their disabilities, when that need is certified by a licensed physician. The nature of the child's disability, the reason the disability prevents the child from eating the regular school meal, and the specific substitutions needed must be specified in a statement signed by a licensed physician.

USDA guidelines differentiate between a licensed physician and a medical authority. A physician is a person licensed by the State to practice medicine. The term includes osteopathic physicians or doctors of osteopathic medicine. These are fully trained physicians who are licensed by the State to prescribe medication or to perform surgery. A recognized medical authority is a licensed physician, physician assistant, nurse practitioner or other health professional specified by the State agency. In the case of food allergy or food intolerance, a licensed physician must certify the condition in order for it to be considered a disability. Once that has been documented in writing, it is permissible to accept specific orders and/or parameters for food substitutions from a recognized medical authority as well as a licensed physician.

In most cases, children with disabilities can be accommodated with little extra expense or involvement. There are situations, however, which may require additional equipment or specific technical training and expertise. When these instances occur, it is important that school food service managers and parent(s) be involved from the beginning in preparations for the child's entrance into the school. This guidance describes some of the factors which must be considered in the early phases of planning and suggests ways in which the school food service can interact with other responsible parties in the school and the community at large to serve children with disabilities.

The guidance is based on the policy guidelines outlined in the FNS Instruction 783-2, Revision 2, *Meal Substitutions for Medical or Other Special Dietary Reasons.* Serving children with disabilities presents school food service staff with new challenges as well as rewards. This guidance presents information on how to handle situations that may arise and offers advice about such issues as funding and liability. The guidance was prepared in consultation with the U.S. Department of Justice and the U.S. Department of Education and will be periodically updated to reflect new scientific information or new statutory and program guidelines.

ACCOMMODATIONS FOR CHILDREN WITH SPECIAL DIETARY NEEDS

Are schools required to make menu substitutions for children who cannot eat the regular lunch or breakfast?

Federal law and the regulations for the National School Lunch Program and the School Breakfast Program require schools to make accommodations for children who are unable to eat the school meal as prepared because of a disability. Accommodation generally involves substituting food items, but in some cases schools may need to make more far reaching accommodations to meet the needs of children. For example, some children may need to have the texture modified.

In order to make substitutions for items in reimbursable meals, the school must have on file a written statement signed by a licensed physician indicating the child's disability, what foods must be omitted from the child's diet, and what foods must be substituted.

Schools may, at their option, make substitutions for persons who have special needs that do not meet the definition of disability under Federal law. In these instances, the school must have a written statement signed by a recognized medical authority (e.g., nurse or physician's assistant) indicating what foods should be substituted.

The purpose of requiring a written statement is two-fold. First, it ensures that the nutrition integrity of the school meal will not be compromised by the substitution. More importantly, it ensures that decisions about specific food substitutes are made by persons who are highly qualified to prescribe them. Therefore, this requirement helps to protect both the child and the food service personnel who are working to meet the child's needs.

Who qualifies as a physician or other recognized medical authority?

A physician is a person licensed by the State to practice medicine. The term includes osteopathic physicians or doctors of osteopathic medicine. These are fully trained physicians who are licensed by the State to prescribe medication or to perform surgery. A recognized medical authority is a licensed physician, physician assistant, nurse practitioner or other health professional specified by the State agency.

SCHOOL ISSUES

The school food service department, like other programs in the school, is responsible for ensuring that its benefits (meals) are made available to all children, including children with disabilities. This raises questions in a number of areas:

A. What are the responsibilities of the school food service department?
B. Where additional funds can be obtained?
C. Who can provide more information and technical assistance?

SCHOOL FOOD SERVICE RESPONSIBILITIES

- School food service staff **must** make food substitutions or modifications **for students with disabilities.**
- Substitutions or modifications for children with disabilities must be based on a prescription written by a licensed physician. This must include a statement by the physician identifying the child's disability, how this disability restricts the child's diet, the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.
- Substitutions **for children without disabilities**, with medically certified special dietary needs are recommended whenever possible, but are **not required**. Substitutions must be based on a statement by a recognized medical authority. This statement must include an identification of the medical or special dietary condition, the food or foods to be omitted from the child's diet, and food or choices of foods to be substituted.

Note: For USDA's basic guidelines on meal substitutions and accessibility, see FNS Instruction 783-2, Revision 2, *Meal Substitutions for Medical or Other Special Dietary Reasons*, in **Appendix A**. It is important that all recommendations for accommodations or changes to existing diet orders be documented in writing to protect the school and minimize misunderstandings. Schools should retain copies of special, non-meal pattern diets on file for reviews. The diet orders do not need to be renewed on a yearly basis; however schools are encouraged to ensure that the diet orders reflect the current dietary needs of the child.

PROVIDING SPECIAL MEALS TO CHILDREN WITH DISABILITIES

The school food service is required to offer special meals, at no additional cost, to children whose disability restricts their diet as defined in USDA's nondiscrimination regulations, 7 CFR Part 15b.

- If a child's Individualized Education Plan (IEP) includes a nutrition component, the school should ensure that school food service managers are involved in the early stages of decisions regarding special meals or modifications.
- The school food service is not required to provide meal services to children with disabilities when the meal service is not normally available to the general student body.

*For example, if a school breakfast program is not offered, the school foodservice is not required to provide breakfast to the child with a disability.

***However, if a student is receiving special education and has an IEP, and the IEP indicates that the child needs to be served breakfast at school, then the school is required to provide this meal to the child and may choose to have the school food service handle the responsibility. This is discussed in more detail in *Section V*, under Situation 2**.

MENU MODIFICATIONS FOR CHILDREN WITH DISABILITIES

Children with disabilities who require changes to the basic meal (such as special supplements or substitutions) are required to provide documentation with accompanying instructions from a licensed physician.

TEXTURE MODIFICATIONS FOR CHILDREN WITH DISABILITIES

The USDA recommends that:

- For children with disabilities who only require modifications in texture (such as chopped, ground, or pureed foods), a licensed physician's written instructions indicating the appropriate food texture is recommended, but not required.
- The State agency or school food authority may apply stricter guidelines, and require that the school keep on file a licensed physician's statement concerning needed modifications in food texture.

In order to minimize the chance of misunderstandings, it is recommended that the school food service, at a minimum, maintain written instructions or guidance from a licensed physician regarding the texture modifications to be made. For children receiving special education, the texture modification should be included in the IEP. School food service staff must follow the instructions that have been prescribed by the licensed physician.

Under no circumstances is school food service staff to revise or change a diet prescription or a medical order.

School food authorities are **not required** to accommodate student and family dietary choices based on ethnic, cultural, or religious preference. However, it is recommended that the school food authority accommodate these requests whenever feasible.

PERSONAL RESPONSIBILITY IN CASES OF NEGLIGENCE

In order to accommodate a child with a disability, the school must ensure that both the facility and personnel are adequate to provide necessary services. In some cases, it may be advisable for specially trained personnel, such as a Registered Dietitian, to provide guidance to the school food service staff on how to modify a child's meals to comply with requirements as provided in the licensed physician's statement. Moreover, for certain children with disabilities, it may be necessary to have a nurse or trained health aide feed the child or have a specially trained professional, such as a special education teacher, occupational therapist, or speech therapist, assist the child to develop and improve his or her eating skills.

ADMINISTERING FEEDINGS

For children requiring assistance in eating, the determination of who will feed the child is a local school decision. While the school food service is specifically responsible for providing the necessary foods needed by a child with a disability, it is not the specific responsibility of the school food service staff to physically feed the child. Furthermore, schools should be aware that they could be held liable if persons without sufficient training are performing tasks or activities such as developing or modifying a diet order prescribed by a licensed physician or administering tube feedings.

NEGLIGENCE

If a mishap should occur, personal liability would normally depend on whether or not the person responsible for the feeding had been negligent. In these cases, a determination that a person acted negligently would be made on the basis of State laws and the facts in the individual situation. In general, negligence occurs when a person fails to exercise the care expected of a prudent person. Persons involved with special feeding responsibilities should understand and implement the required procedures and techniques. For specific guidance concerning personal liability, the school officials should contact State or local legal counsel.

FUNDING SOURCES

PRICE OF MEALS

Meals must be served free or at a reduced price (a maximum of 40 cents for lunch and 30 cents for breakfast) to children who qualify for these benefits regardless of whether or not they have a disability. Schools may **not** charge extra for meals requiring food substitutions or modifications for children with disabilities or certified special dietary needs.

INCURRING ADDITIONAL EXPENSES

In most cases, children with disabilities can be accommodated with little extra expense or involvement. If additional expenses are incurred in providing food substitutions or modifications for children with special needs, generally the school food authority should be able to absorb the cost of making meal modifications or paying for the services of a Registered Dietitian. However, when the school food service has difficulty covering the additional cost, there are several alternative sources of funding which school food service managers, school administrators, parents or guardians, and teachers may consider. These sources include the school district's general fund and the additional funding sources listed below. Any additional funding received by school food services for costs incurred in providing special meals must accrue to the nonprofit school food service account.

POTENTIAL FUNDING SOURCES

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

The *Individuals with Disabilities Education Act* (IDEA), through the Part B Program, provides Federal funds to assist States and school districts in making "free appropriate public education" available to eligible children with specified disabilities residing within the State. Students with specified physical, mental, emotional or sensory impairments that need special education and related services are eligible for services under IDEA, **at no cost to parents.** In appropriate situations, nutrition services may be specified as **special education** (specially designed instruction) or a **related service** (support services required to assist a child with a disability to benefit from special education). Services which may be funded through IDEA include:

(1) Purchase of special foods, supplements, or feeding equipment
(2) Consultation services of a registered dietitian or nutrition professional
(3) Assistance of a special education teacher, occupational therapist or other health professional in feeding the child or developing feeding skills.

Website address: Department of Education/IDEA: www.ed.gov
(scroll down to "Most Requested Items" Disabilities Education (IDEA))

MEDICAID

Title XIX of the *Social Security Act* is an entitlement program which finances medical services for certain individuals and families with low income and resources. Within broad Federal guidelines, a State or territory:

- Establishes its own eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets the rates of payment for services
- Administers its own program

The Medicaid program, jointly funded by Federal and State governments, varies considerably from State to State as each State adapts the program to its own unique environment. In the case of certain low-income children eligible for Medicaid, Medicaid may pay for services that are medical and remedial in nature. These services may include special dietary supplements, eating devices, and nutritional consultation as medically

necessary. Medicaid reimbursement is paid directly to the provider of services, such as a physician, pharmacy, medical equipment supplier, clinic, and, in certain situations, the Local Education Agency (LEA) and/or school. Questions regarding provider qualifications should be directed to the Arizona State Medicaid agency. If you have questions about who has access to Medicaid, how to qualify as an authorized provider, or what services are covered by Medicaid in your State, contact the Arizona State Medicaid agency. For information or a referral, check with the Medicaid division, at the regional office of the Health Care Financing Administration for Arizona:

SAN FRANCISCO REGIONAL OFFICE
90-7th Street, Suite 5-30
San Francisco, CA 94103-6706
Medicaid Associate Regional Administrator 415-744-3501
Website address: www.cms.gov/regionaloffices

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT PROGRAM
Medicaid's child health program, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program is a preventive and comprehensive health care benefit for Medicaid-eligible individuals up to 21 years old. EPSDT includes screening for dental, hearing and vision services. An objective of the EPSDT Program is to detect and treat health problems and conditions early before they become more complex and costly. The EPSDT Program allows providers, including schools, to be reimbursed for preventive and treatment services for Medicaid-eligible children. Questions regarding EPSDT coverage under Medicaid should be directed to the State Medicaid agency or to any DES or AHCCCS office.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Member Services call:
(602) 417-7000 within Maricopa County
(800) 962-6690 In-state Toll-free
Telecommunications Device for the Deaf (TDD) (602)417-4191
Website address: www.azahcccs.gov

SUPPLEMENTAL SECURITY INCOME
Supplemental Security Income (SSI), under Title V of the *Social Security Act*, provides rehabilitative services to children under age 16 who are receiving benefits under SSI, to the extent that Medicaid does not cover the service. SSI provides basic income for needy children under age 18 (students under 22 years old) who are blind or who have a severe disability or chronic illness. For information on SSI eligibility, contact your local Social Security Office or call the Social Security Administration's toll free telephone number, 1-800-772-1213, (TTY/TDD, 1-800-325-0778).
Website address: www.SSA.gov (scroll down to Supplemental Security Income)

MEDICARE
Medicare provides services for children and adults with end-stage renal (kidney) disease. However, Medicare coverage of nutritional supplies is generally limited to durable medical equipment such as a feeding pump or other special (parenteral or enteral) nutritional feeding equipment necessary for people who cannot be sustained through normal means of feeding by mouth. For more information, call the toll free Medicare Hotline at, 1-800-633-4227 or (TTY/TDD, 1-800-820-1202).
Website address: www.medicare.gov

MATERNAL AND CHILD HEALTH (MCH) SERVICES BLOCK GRANTS

The Maternal and Child Health Bureau, at the Department of Health and Human Services, administers Maternal and Child Health Services Block Grants, authorized under Title V of the *Social Security Act*. These grants enable States to assess health needs and provide a wide range of community-based services for children with special health care needs. State Title V programs work closely with community health centers, public health clinics, and school health programs. Contact the Regional MCH Program Consultant for Arizona, listed under Medicaid on page 5, for information about Title V program activities.

COMMUNITY SOURCES

Parent Teacher Associations (PTA), voluntary health associations, local civic organizations, and other community-based groups may be able to assist with the procurement of equipment and provide other support services. See page 55 for a partial list of voluntary and professional health organizations which offer information and support for various disabilities or special health care needs.

LEGAL CONCERNS AND LIABILITY IN WORKING WITH CHILDREN WITH DISABILITES

A growing body of Federal law clearly intends that children with disabilities have the same rights and privileges, and the same access to benefits, such as school meals, as children without disabilities. Consequently, schools which do not make appropriate program accommodations for children with disabilities, could be found in violation of Federal civil rights laws. School administrators and food service staff should be aware of two issues involving liability: (1) the school's responsibility for providing program accommodations for children with disabilities and (2) the question of personal responsibility in cases of negligence.

HELPFUL RESOURCES

School food service staff should work closely with personnel who are familiar with the needs of the child. The child's parents or guardians, teachers, occupational and physical therapists, special education staff, and the school nurse are valuable resources.

Local health department, hospital, or medical center registered dietitians may be able to provide assistance in understanding diet orders, developing and modifying meal plans, menus, special food item purchases, and other aspects of feeding children with special needs. In addition, the following resources may provide technical assistance or referrals to qualified nutrition and health professionals.

REGISTERED DIETITIANS OF THE AMERICAN DIETETIC ASSOCIATION (ADA)

Registered Dietitians (RD) can answer questions on special diets and menu planning to help school food service staff better understand a child's special dietary needs. An RD may work with the recognized medical authority and the school food service to help meet a child's special nutritional needs and ensure that menus comply with the diet order. These types of services are allowable program costs. The ADA's toll free Consumer Nutrition Information/Hotline is 1-800-877-1600 which can provide referrals to qualified RDs in your area as well as daily nutrition messages.
Website address: www.eatright.org

UNIVERSITY AFFILIATED PROGRAMS FOR DEVELOPMENTALLY DISABLED (UAP)

UAPs were established to support the independence, productivity, and community integration of all citizens with developmental disabilities. Within their States, UAPs serve as links between the academic world and the delivery of services to persons with developmental disabilities. UAPs also provide families and individuals with a variety of support services. For a referral to a UAP in your area, contact the National Office of the American Association of University Affiliated Programs at (602) 523- 4791.
Website address: www.aauap.org

REGIONAL DISABILITY AND BUSINESS TECHNICAL ASSISTANCE CENTERS

Ten regional centers are funded by the National Institute on Disability Rehabilitation and Research of the U.S. Department of Education to provide information and technical assistance on the Americans with Disabilities Act (ADA). The Regional ADA Coalition in your area may also be helpful. Copies of ADA documents, supplied by the Equal Employment Opportunity Commission and the Department of Justice, may be obtained at any of the regional centers. These materials are available in standard print, large print, Braille, on audiocassette and computer disk. For the telephone number and address of your regional center, call the ADA Technical Assistance Center's toll free number:1-800-949-4ADA.

OTHER HEALTH CARE AND DISABILITY RELATED ORGANIZATIONS

Websites of Interest, found on page 55, lists organizations which may offer assistance regarding children with different health care needs. Included are such organizations as the American Diabetes Association, the Food Allergy and Anaphylaxis Network, United Cerebral Palsy Association, the Easter Seal Society, and many more.

CHILDREN WITH DISABILITIES

DEFINITION:

REHABILITATION ACT OF 1973 AND THE AMERICANS WITH DISABILITIES ACT

Under Section 504 of the *Rehabilitation Act of 1973,* and the *Americans with Disabilities Act* (ADA) of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. The term "physical or mental impairment" includes many diseases and conditions, a few of which may be:

- Orthopedic, visual, speech, and hearing impairments
- Cerebral palsy
- Epilepsy
- Muscular dystrophy
- Multiple sclerosis
- Cancer
- Heart disease
- Metabolic diseases, such as diabetes or phenylketonuria (PKU)
- Food anaphylaxis (severe food allergy)
- Mental retardation
- Emotional illness
- Drug addiction and alcoholism
- Specific learning disabilities
- HIV disease
- Tuberculosis

Please refer to the Acts noted on page 5 for a more detailed explanation. Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

The term child with a "disability" under Part B of the *Individuals with Disabilities Education Act* (IDEA) means a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, need special education and related services. IDEA recognizes thirteen disability categories which establish a child's need for special education and related services. These disabilities include:

- Autism
- Deaf-blindness
- Deafness or other hearing impairments
- Mental retardation
- Orthopedic impairments
- Other health impairments due to chronic or acute health problems, such as asthma, diabetes, nephritis, sickle cell anemia, a heart condition, epilepsy, rheumatic fever, hemophilia, leukemia, lead poisoning, tuberculosis
- Emotional disturbance
- Specific learning disabilities

• Speech or language impairment
• Traumatic brain injury
• Visual impairment; including blindness which adversely affects a child's educational performance
• Multiple disabilities

Attention deficit disorder or attention deficit hyperactivity disorder may fall under one of the thirteen categories. Classification depends upon the particular characteristics associated with the disorder and how the condition manifests itself in the student, which will determine the category.

The **INDIVIDUALIZED EDUCATION PROGRAM** or IEP is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. The IEP is the cornerstone of the student's educational program that contains the program of special education and related services to be provided to a child with a disability covered under the IDEA.

Schools which receive Federal funding assistance under the child nutrition programs continue to be subject to the non-discrimination requirements of Section 504 Americans with Disabilities Act: Title III

PRIVATE AND RELIGIOUS SCHOOLS

Title III of the ADA extends requirements for public accommodations to privately owned facilities. All private schools participating in the federally funded child nutrition programs must make accommodations to enable children with disabilities to receive school meals.

PHYSICIAN'S STATEMENT FOR CHILDREN WITH DISABILITIES

USDA regulations 7 CFR Part 15 (b) require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability **MUST** be provided substitutions in foods when that need is supported by a statement signed by a licensed physician. The physician's statement must identify:

- The child's disability;
- An explanation of why the disability restricts the child's diet;
- The major life activity affected by the disability; and
- The food or foods to be omitted from the child's diet, and food or choice of foods that must be substituted

SPECIAL SITUATIONS AND RESPONSES

The following topics and examples of situations that might occur are intended to illustrate relatively practical guidelines and principles not as the final word on similar situations involving specific students at a specific school. Remember that circumstances vary from case to case and each situation should be evaluated and decided on an individual basis:

MEALS AND/OR FOODS OUTSIDE OF THE NORMAL MEAL SERVICE

Situation 1:

As part of therapy for a child with a disability, the licensed physician has required the child to consume six cans of cranberry juice a day. The juice is to be served at regular intervals, and some of these servings would occur outside of the normal school meal periods. Is the school food service required to provide all of the servings of juice?

Response:

No. The general guideline is that children with disabilities must be able to participate in and receive benefits from programs that are available to children without disabilities.

In this instance, the school food authority would be required to provide and pay for cranberry juice as part of the regular reimbursable breakfast, lunch, and/or snack service. However, the school food service would not be required to pay for other servings throughout the school day unless so specified in the student's IEP.

It should be recognized that there may be exceptions to this general rule. For instance, a Residential Child Care Institution (RCCI) such as a juvenile correction facility or boarding school, where children have no other recourse for meals, may be required to provide all the needed juice.

In addition, not all juice servings need to be charged to the nonprofit food service account.

Situation 2:

A child with a disability must have a full breakfast each morning. Is the school food service required to provide a breakfast for this child even though a breakfast program is not available for the general school population?

Response:

No. The school food service is not required to provide services that would not normally be available to the general school population. If the school food authority does not have a breakfast program, they would not be required to start one for children with a disability.

However, if the IEP requires that a child receive a breakfast at school, the school must provide the service. The food service program may or may not be responsible for this service. The school and/or district may have health or other personnel that can provide this student's required breakfast.

As in the previous example, a RCCI must provide the breakfast as the student would not have any other source for meeting this requirement.

Situation 3:

A licensed physician has prescribed portion sizes that exceed the minimum serving size requirements set forth in the regulations for a child with a disability. Is the school required to provide these additional quantities?

Response:

Yes. The school must provide the child food serving sizes which exceed the minimum serving size requirements, if specifically prescribed in the licensed physician's statement.

SPECIAL NEEDS WHICH MAY OR MAY NOT INVOLVE DISABILITIES
Situation 1:

A child has a life-threatening allergy to peanuts. It is reported that the slightest contact with peanuts or peanut derivatives, usually peanut oils, could result in a potentially fatal anaphylactic reaction. To what lengths must the food service department go to accommodate the child? Is it sufficient for the school food service to post or avoid obvious foods such as peanut butter, or must the school food service staff research every single ingredient in all foods and post these?

Response:

In short, the food service staff must do whatever is necessary. The school is required to provide a safe, non-allergic meal to the child if it is determined that the condition is disabling. To do so, school food service staff must make sure that all food items offered to the allergic child meet prescribed guidelines and are free of foods which could potentially cause a reaction. Food service staff should not serve any item whether it is processed or made from scratch that could be detrimental to the student. In general, food service staff should never serve any item that lacks sufficient content information to ensure student safety. School food service staff should take care to avoid cross-contamination while preparing the student's meal. Separate work areas and tools are recommended.

Additionally, it is important to recognize that a child may be provided an equivalent meal served to others but not necessarily the same meal.

Resources for children with food allergies: Food Allergy and Anaphylaxis Network Inc.
Web site: **www.foodallergy.org**

Situation 2:

A child's parents have requested that the school prepare a strict vegetarian diet for their child based on a statement from a health food store's "nutrition advisor". Must the school comply with the request?

No. The school is only responsible to make accommodations for conditions that are considered a disability. Part of this definition includes a diagnosis/statement from a licensed physician as described in 7 CFR Part 15b. The school may, but is not required to meet this request.

RESPONSIBILITIES OF FOOD SERVICE MANAGEMENT COMPANIES (FSMC) AND OTHER FOOD SERVICE OPERATIONS
Situation 1:

A school district has contracted with a FSMC to operate the school's food service. Is the FSMC obligated to accommodate children with disabilities?

Yes. Since schools must provide for the needs of children with disabilities, their contracts with FSMC should reflect this requirement. Even if the school food authority does not have any students with disabilities at the time of the contract bid, some statement should be included in the contract with the FSMC to ensure that any needs that arise for students with disabilities will be covered by the FSMC.

Arizona Department of Education
Heath and Nutrition Services
School Health and Nutrition Programs

DIET ORDER

Medical Statement for Student with Special Diet Needs

Part I (to be filled out by parent or guardian)

Name of Student: *(Last)* _____ *(First)*_____ *(MI)*_____

Date of Birth _____/_____/_____ Age _____

School Attended by Student _____

Parent/Guardian's Daytime Phone Number(s) ( ) _____–_____ ( ) _____–_____

Name of Parent/Guardian(s)_____

Signature of Parent/Guardian _____

Part II (to be filled out by Physician)

Patient's Diagnosis _____

Describe the patient's condition and the major life activity affected by the condition related to the need for dietary modification:

_____

_____

_____

Indicate the necessary dietary modification and **specify the changes to be made:**

__Texture Modification: __ Pureed __Ground __Chopped __Other _____

Specify Foods _____

__Tube Feeding: Formula Name _____

Administering Instructions _____

Oral Feeding: __ No __Yes If Yes, Specify Foods _____

__Nutrient Modification: __Increase Calories Description: _____

_____

_____

Supplement Name: _____

__Decrease Calories Description: _____

_____

_____

__Nutrient Restriction Description: _____

__Special Mealtime Equipment: _____

Dietitian's Name *(if available)*: _____Phone ( ) _____-_____

Physician's Name _____ Phone ( ) _____-_____

Address_____

PHYSICIAN SIGNATURE _____ Date _____

PURPOSE: To record the student's condition requiring dietary modifications of school lunch and the changes to be made.

PREPARATION: The parent or guardian of the child is responsible for obtaining the form, filling out Part I, requesting completion of Part II by a physician, and delivering the form to the school office attended by the child. A licensed physician is responsible for completing Part II of the document based on the child's medical condition. Consultation by a dietitian for completion of the form, if needed, should be requested by the parent or physician.

INSTRUCTIONS:

Part I (to be filled out by parent or guardian):

Name of Student: Enter the student's last name, first name, and middle initial..

Date of Birth: Enter the student's six-digit date of birth, e.g., May 21, 1988 = 05/21/88.

Age: Enter the student's one- or two-digit age, in years, as of the day the form is completed.

School Attended by Student: Enter the name of the school which the student regularly attends.

Parent/Guardian's Daytime Phone Number(s): Daytime telephone number(s), complete with the area code(s), for a parent(s)/guardian(s).

Name of Parent(s)/Guardian(s): Enter the full name of the student's parent(s) or legal guardian(s).

Signature of Parent/Guardian: Enter the signature of one parent or legal guardian's name. The printed name should correspond to the signature.

Part II (to be filled out by physician):

Patient's Diagnosis: Insert the patient's clinical diagnosis for the condition which requires dietary modification.

Description of patient's condition and major life activity affected by the condition related to dietary modification:
Describe the patient's condition as it affects a major life activity (i.e., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, etc.). Describe how the restrictions of the patient's condition affect his or her diet.

Indicate the necessary dietary modification and specify the changes to be made: Check the type(s) of modification the patient's condition requires and fill in the corresponding specification with the changes that should be made. A dietitian can assist in completing this section.

Dietitian's Name (if applicable): Provide a local dietitian's name and phone number.

Physician: Print the name, address, and phone number of the physician completing the form.

Physician Signature: Enter the signature of the physician filling out the form and the date signed.

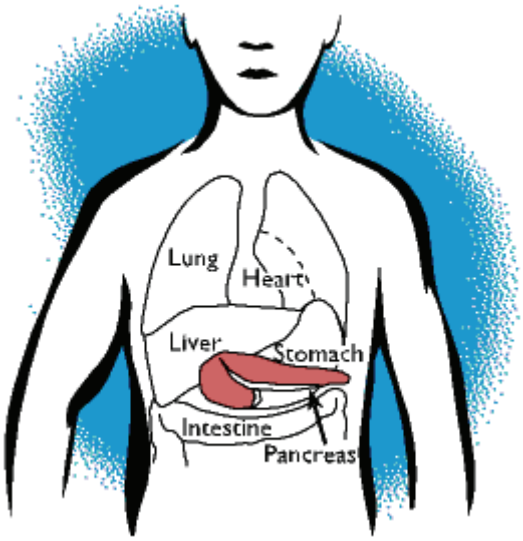
DIABETES

GENERAL INFORMATION

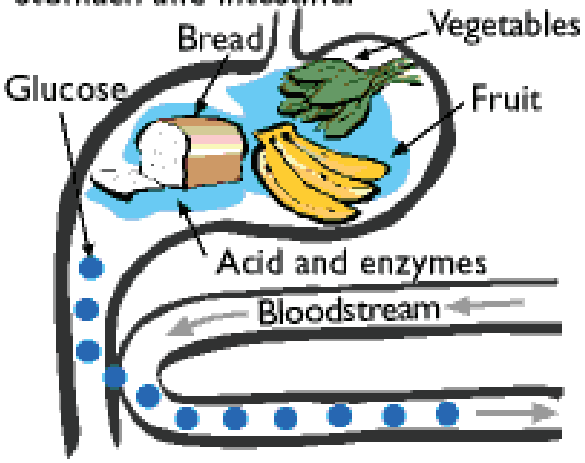
After eating and digesting food in the stomach and the upper part of the intestines, the nutrients from the digested food are absorbed into the bloodstream. The carbohydrates (sugars and starches) in food are broken down into glucose which enters the bloodstream. This glucose is used immediately for energy or can be stored in the liver or muscle as a substance called glycogen.

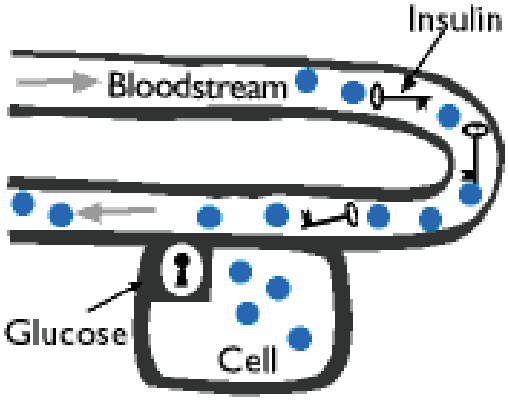
Glucose is the major energy source for the cells of the body. Glucose can only pass from the bloodstream into cells if insulin is present. Therefore, insulin is required for cells to utilize glucose. If there is no insulin, glucose will stay in the bloodstream causing the glucose levels to rise above normal and at the same time depriving the cells of energy.

Fat can be used as an alternative energy source. Ketones are the by-product of fat metabolism. In people without diabetes, ketones are produced from fat when supplies of glucose are becoming low, such as during fasting or illness. This can also be the case in people with diabetes. However, it is more common for ketones to be produced because there is a lack of insulin (or keys) and the glucose that is present in the blood is unable to be used for energy.



Carbohydrates in our food are turned into glucose in the stomach and intestine.





Insulin opens the door so that glucose can enter the cell to be used as energy.

How insulin helps the body use glucose from the bloodstream for energy

Source: http://www.rch.org.au/diabetesmanual/manual.cfm?doc_id=2729 (Diabetes Manual)

OVERVIEW

There are two types of diabetes, Insulin-Dependent Diabetes Mellitus: IDDM (formally known as Type 1 Diabetes) and Noninsulin-Dependent Diabetes Mellitus: NIDDM (formally known as Type 2 Diabetes). **IDDM** is usually diagnosed in children and young adults, and was also previously known as juvenile diabetes. With IDDM, the body does not produce insulin. Insulin is necessary for the body to be able to use sugar. Sugar or carbohydrates in food become known as blood glucose once absorbed into the blood. Glucose is the basic fuel for the cells in the body, and insulin acts as a key to take the glucose from the blood into the cells.

NIDDM is the most common form of diabetes. With NIDDM, either the body does not produce enough insulin or the cells ignore the insulin. Insulin is necessary for the body to be able to allow glucose into the cells. When glucose builds up in the blood instead of going into cells, it can cause cells to be starved for energy immediately and over time. Those high blood glucose levels may damage your eyes, kidneys, nerves, and/or heart.

While diabetes occurs in people of all ages and races, some groups have a higher risk for developing NIDDM diabetes than others. NIDDM is more common in African Americans, Latinos, Native Americans, and Asian Americans/Pacific Islanders, as well as the aged population. NIDDM is increasing rapidly in children, especially in the Native American cultures. Children as young as 10 years old are being diagnosed with NIDDM.

Data from the American Diabetes Association 2011 National Diabetes Fact Sheet (released Jan. 26, 2011)

TOTAL PREVALENCE OF DIABETES

Total: 25.8 million children and adults in the United States—8.3% of the population—have diabetes.

Diagnosed: 18.8 million people

Undiagnosed: 7.0 million people

Prediabetes: 79 million people*

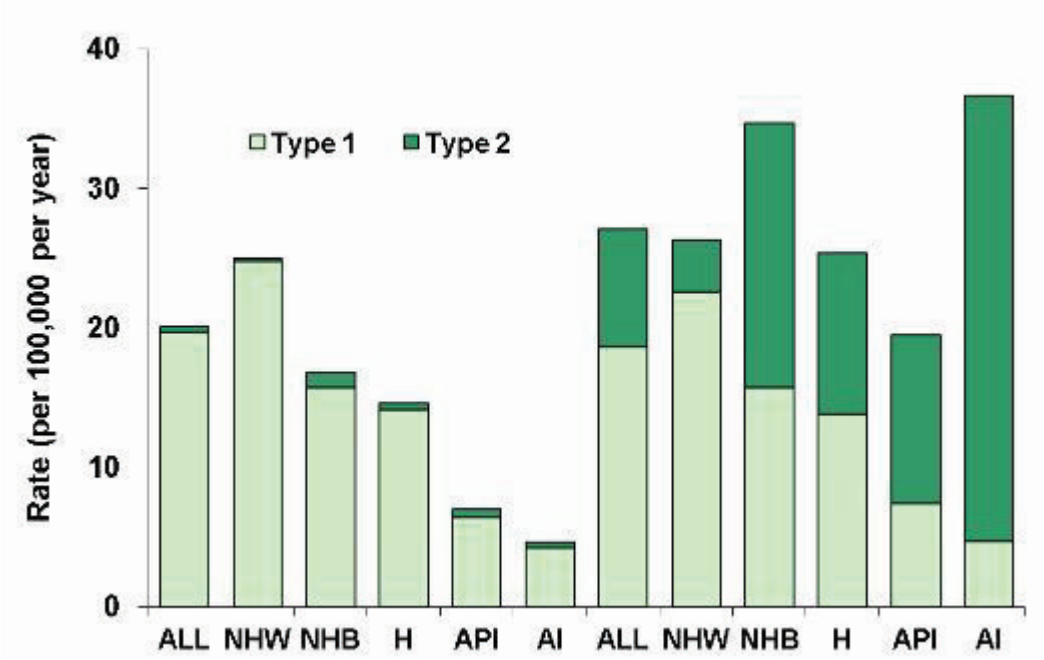
Under 20 years of age

- 215,000, or 0.26% of all people in this age group have diabetes
- About 1 in every 400 children and adolescents has type 1 diabetes

Age 20 years or older

- 25.6 million, or 11.3% of all people in this age group have diabetes

Rate of new cases of type 1 and type 2 diabetes among youth aged < 20 years, by race/ethnicity, 2002–2005



- Source: SEARCH for Diabetes in Youth Study
  NHW=non-Hispanic whites; NHB=non-Hispanic blacks; H=Hispanics; API=Asians/Pacific Islanders; AI=American Indians

In 2000, the World Health Organization (WHO) estimated that over 177 million people have diabetes. By 2025, this figure will top 300 million.

CONSEQUENCES OF UNTREATED DIABETES

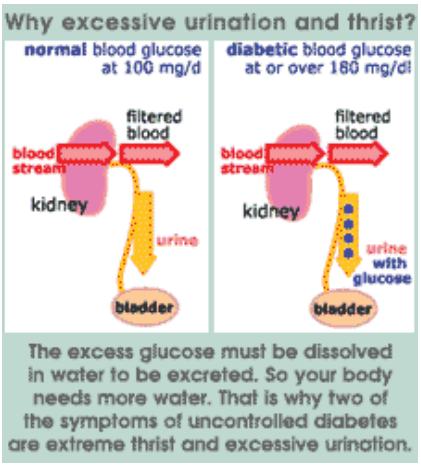
A number of complications will arise from untreated or uncontrolled diabetes including:

- **Ketosis and Coma** (Build up of ketone bodies in the blood stream will alter the pH of the blood. If unchecked, the high levels of acid in the blood stream may lead to a fatal coma.)
- **Serious Weight Loss in IDDM (Type 1 Diabetes)**
- **Weight Gain in NIDDM (Type 2 Diabetes)**
- **Hypoglycemia (Low Blood Sugar)** (Symptoms include: hunger, headache, sweating, shakiness, nervousness, confusion, disorientation, and slurred speech.)
- **Cardiovascular Diseases**
- **Microangiopathies** (Disorders of the small blood vessels, which may lead to kidney failure and blindness.)
- **Neuropathy** (Loss of feeling in the hands and feet due to poor circulation.)

DIAGNOSING DIABETES

Some diabetes symptoms include:

- Frequent urination
- Excessive thirst
- Extreme hunger
- Unusual weight loss (IDDM)
- Increased fatigue
- Irritability
- Blurry vision



www.diabetesand-diabetics.com/index.php

LIVING WITH DIABETES

The most important goal for living with diabetes is to maintain blood glucose levels within a fairly normal range (80-120 mg/dL before meals and 100-140 mg/dL at bedtime). For IDDM this will entail the daily monitoring of blood glucose levels. For NIDDM spacing out meals into 6 small servings per day with a variety of healthy choices from all the food groups, will help to keep a more consistent blood glucose level. Exercise is also a very important component for controlling NIDDM. Some NIDDM are also required to monitor their blood glucose levels.

DIETARY REQUIREMENTS

A diabetic diet is actually not too different from the diet recommendations for all people. More emphasis on monitoring carbohydrate intake on a day by day basis is the most significant difference. Children with IDDM need to be offered a balanced diet, with meals taken at about the same intervals each day. This pattern of consistent, healthy, well balance meals will provide the optimal environment for proper growth and development for children with IDDM. Both types of diabetics are encouraged to consume complex carbohydrates, consisting of more whole grain products, beans (legumes), fruits and vegetables.

FOODS TO AVOID

There are no forbidden foods on a diabetic diet. The simple rules of thumb are everything in moderation and avoid too much ingestion of simple sugars. Simple sugars include such items as candy, cakes, cookies, soda and other foods containing high amounts of processed sugar in the diet as it will cause blood glucose levels to rise rapidly.

MANAGING DIABETES IN A SCHOOL FOOD SERVICE SETTING

The diabetic student requires a little more attention from school food service staff than the regular population. Consider the diabetic student in meal planning. Some points to consider include:

- Offer a good variety of foods
- Add or replace carbohydrates and other menu items, if necessary
- Replace “sweet desserts” with fruit
- Allow diabetic students to make their own food choices from the school lunch menu
- Provide parents with a copy of the school lunch menu in advance so they can help their child make appropriate food choices
- Provide carbohydrate counts of menu items to parents and students and post in the cafeteria

INFORMATION RESOURCES

AMERICAN DIABETIC ASSOCIATION

The American Diabetes Association is the nation's leading nonprofit health organization providing diabetes research, information and advocacy. Founded in 1940, the American Diabetes Association conducts programs in all 50 states and the District of Columbia, reaching hundreds of communities.
The mission of the Association is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.
http://www.diabetes.org/

AMERICAN DIETETIC ASSOCIATION

216 W. Jackson Blvd.
Chicago, IL 60606-6995
312-899-0040 or 800-877-1600
www.eatright.org

AMERICAN HEART ASSOCIATION NATIONAL CENTER

7272 Greenville Avenue
Dallas, TX 75231
800-AHA-USA-1 or 800-242-8721
www.americanheart.org/

AMERICAN OPTOMETRIC ASSOCIATION

243 North Lindbergh Blvd.
St. Louis, MO 63141
314-991-4100
Fax: 314-991-4101
www.aoanet.org/

DIABETES EXERCISE AND SPORTS ASSOCIATION

P. O. Box 1935
Litchfield Park, AZ 85340
623-535-4593 or 800-898-432
www.diabetes-exercise.org/

INDIAN HEALTH SERVICE NATIONAL DIABETES PROGRAM

5300 Homestead Road NE
Albuquerque, NM 87110
505-248-4182
Fax: 505-248-4188
www.ihs.gov/MedicalPrograms/Diabetes/index.asp

JUVENILE DIABETES RESEARCH FOUNDATION INTERNATIONAL
120 Wall Street
New York, NY 10005-4001
800-533-CURE (2873) or 212-785-9500
Fax: 212-785-9595
www.jdf.org

CENTERS FOR DISEASE CONTROL DIABETES PUBLIC HEALTH RESOURCE
http://www.cdc.gov/diabetes/pubs/estimates11.htm#3

PHENYLKETONURIA
(PKU)

OVERVIEW

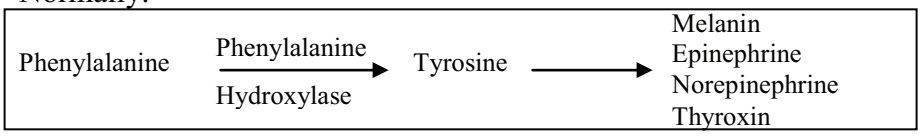
Phenylketonuria (PKU) is a rare inherited metabolic disorder that results from a complete absence or large deficiency of the liver enzyme phenylalanine hydroxylase (PAH). If left untreated the disorder leads to elevated levels of the amino acid phenylalanine in the blood and tissues, most notably brain tissue. Untreated PKU is characterized by mental retardation, microcephaly (small brain size), delayed speech, seizures, eczema, behavior abnormalities, and other symptoms.

GENERAL INFORMATION

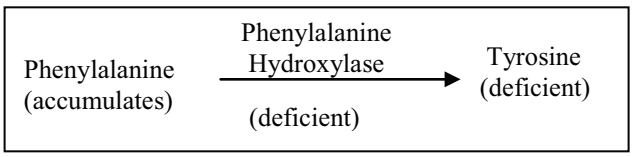
There are about one hundred known amino acids, twenty of which are the main building blocks for human proteins. Ten of the twenty amino acids are essential amino acids since our body cannot make them. Phenylalanine (PHE) is an essential amino acid, which is used for two major purposes: tissue protein synthesis and hydroxylation to form tyrosine. Normally, adult uses only 10% of the recommended dietary allowance (RDA) for PHE (14mg/kg) to make new protein, and about 90% is converted to form the amino acid tyrosine. Because of growth, children use 60% of the required PHE to make new protein, and 40% is converted to form tyrosine. Tyrosine is a non-essential amino acid and is normally a byproduct of PHE metabolism. With normal PHE hydroxylase activity, PHE is converted to tyrosine, which is used to make proteins, catecholamines, melanin pigment, neurotransmitters, and thyroid hormones. Since the body is unable to convert PHE to tyrosine in children with PKU, it becomes an essential amino acid. Without the ability to convert PHE to tyrosine, PHE accumulates in the blood and becomes toxic to brain tissue.

BIOCHEMICAL CHANGES IN THE LIVER

Normally:

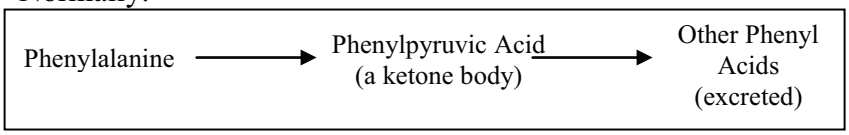


With PKU:

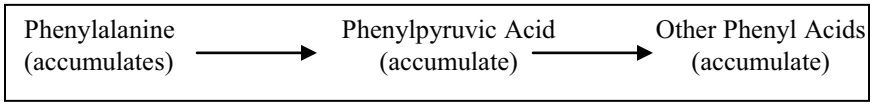


BIOCHEMICAL CHANGES IN THE KIDNEYS

Normally:



With PKU:



CONSEQUENCES OF UNTREATED PKU

Mental Retardation	Abnormal Posturing
Microcephaly (small brain size)	Eczema
Defective Myelin Formation	Light Pigmentation
Seizures	Aggressive Behavior
Delayed Speech	Psychiatric Disturbances
Hyperactivity	Musty Odor
Poor Coordination	

DIAGNOSING PKU

Newborn screening for PKU has been occurring in the United States for over forty years and PKU affects about one of every fifteen thousand births. Babies are tested for PKU before leaving the hospital. A blood sample is collected by pricking the baby's heel and collecting the blood sample onto special paper cards. The test is known as the Guthrie Heel Prick Test. The blood sample is then evaluated for the presence of abnormally high levels of PHE. The test is highly accurate when performed properly. The baby should be more than twenty-four hours old, but less than seven days old when first tested. The infant needs to consume several meals containing protein prior to being tested. If the baby is tested within twenty-four hours from birth it may be too early to accurately detect elevated serum PHE levels. With the increase in early hospital releases and home births some newborns may be tested too early or in some cases too late. If the child is not diagnosed or treated before three weeks of age, irreversible mental retardation can occur. Unfortunately, symptoms are not expressed until the child is about three to six months of age. Early symptoms include skin rash, and light skin pigmentation. Between three and six months, signs of developmental problems begin to appear.

LIVING WITH PKU

The prognosis for children with PKU is very good. The mental retardation can be prevented if the child is diagnosed and treated early in life. It was once believed a child with PKU could discontinue their special diet after about age six because the brain and central nervous system is completely developed by the age of six. However, studies later discovered that older children with elevated serum PHE concentrations did suffer from short attention span, poor short term memory, and poor eye-to-hand coordination. It is now suggested children continue their low PHE diet throughout their lifetime.

DIETARY REQUIREMENTS

The goals of implementing a PKU diet are to restrict PHE foods and supplement tyrosine in order to maintain blood concentrations within a safe range. This will allow for proper growth and brain development. It is important to remember that PHE is an essential amino acid; therefore you cannot remove it from the diet. Children with PKU do not require less PHE than other children they just cannot handle excessive amounts. If PHE intake is too low a child may suffer bone, skin, and blood disorders, growth and mental retardation, or death. So it is important to balance the diet. To help ensure concentrations remain in a safe range, children with PKU receive blood tests periodically and change their diets when necessary.

PHE can be found in large quantities in high protein foods such as meats, fish, poultry, cheese, eggs, milk, nuts, and legumes. The aforementioned foods, as well as products made from regular flour are excluded from the PKU diet. The diet allows foods that contain some PHE, such as fruits, vegetables, and cereals, and those that contain none, such as fats, sugars, jellies, and some candies. Diet drinks and foods that contain the artificial sweetener aspartame (NutraSweet or Equal) must be avoided. One of the components that make-up aspartame is the amino acid phenylalanine.

This target is an easy way to visualize the foods allowed on the diet for PKU. The phenylalanine-free formula, such as Phenly-Free, is the center of the target diet. As the foods get further away from the bull's-eye, they are higher in phenylalanine. The foods outside the target are not included in the low-phenylalanine meal plan and should be avoided.

Source: PKU Clinic, University of

In order to supply adequate energy, protein, and nutrients the PKU diet must include formulas and medical foods that contain very little or no PHE. The less phenylalanine these foods contain the more phenylalanine the child can get from natural foods. The formulas/medical foods supply seventy-five to ninety percent of the child's daily protein and nutrient needs.

FOODS TO AVOID (HIGH IN PHENYLALANINE)

All meat- i.e., beef, pork, ham, bacon, poultry
Fish- including shellfish
Eggs
Cheese
Nuts
Legumes
Milk
Regular bread, flour, cakes, and biscuits
Tofu
Seeds
Products containing Aspartame (NutraSweet or Equal)

ACCEPTABLE FOODS

(For reference only, all foods should be approved by a Physician)

Fruits

Apples	Kiwi
Cherries	Melons
Fruit Pie Filling	Peaches
Fruit Salad	Pears
Grapes	Pineapple
Grapefruit	Plums
Lemons	Raisins
Limes	Strawberries

Banana (limited to one small banana per day)

Vegetables

Cabbage	Onion
Carrots	Peppers
Cauliflower	Pumpkin
Celery	Squash
Cucumber	Sweet Potato
Lettuce	Tomato
Mushrooms	

Fats

Butter
Margarine (except spreads containing buttermilk)
Vegetable fats and oils

Beverages (must not contain Aspartame)

Water	Lemonade
Sparkling water	Soda Pop
Mineral water	100% Fruit Juices
Fruit Punch	Rice Milk (Waitrose and Rice Dream)

Miscellaneous

Herb & Spices	Marmalade
Honey	Maple Syrup
Icing	Mustard
Jam	Salt & Pepper

MANAGING PKU IN A SCHOOL FOODSERVICE SETTING

Once a child with PKU reaches school-age, Local Educational Agencies in accordance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, are required to accommodate the special dietary needs of the child. However, a written physician's order is required which should include a description of the disability, an explanation for how the disability affects the diet, states the dietary changes required, and offers suggested menu modifications. Although medical food and special low protein products are expensive, the school is not allowed to charge the student any more than the current price of the regular breakfast or lunch. When possible, try to offer the student foods that are similar to what is on the standard menu. This may help prevent the student from feeling different from other students.

RESOURCES

Children's PKU Network: **www.pkunetwork.org**
National PKU News: **www.pkunews.org**
National Society for Phenylketonuria: **www.nspku.org**

LOW PROTEIN FOOD/FORMULA RESOURCES

Applied Nutrition:
800-605-0410
www.medicalfood.com

Cambrooke Foods:
508-276-1800
www.cambrookefoods.com

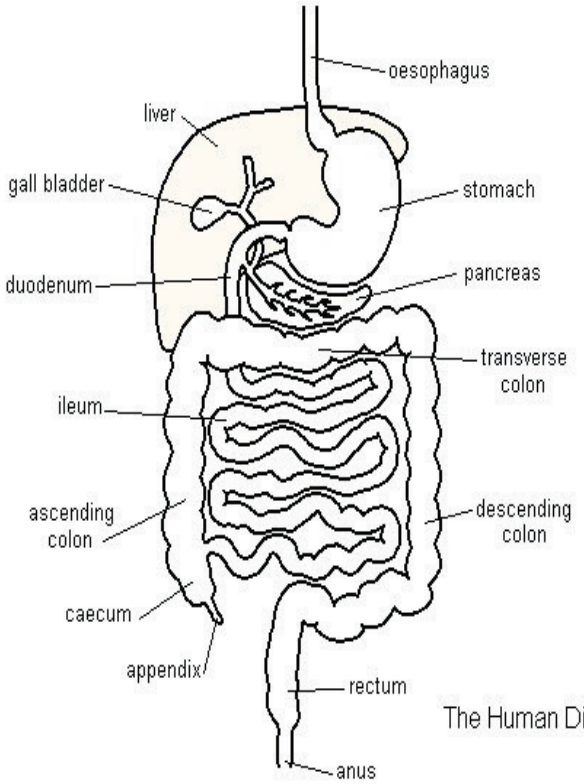
Ener-G Foods:
800-331-5222
www.ener-g.com

Mead Johnson:
812-429-6399
www.meadjohnson.com

CELIAC DISEASE

OVERVIEW

Celiac disease is a genetic digestive disorder that is triggered by the consumption of the protein gluten. Individuals who suffer from celiac disease must avoid foods containing gluten which is found in wheat, rye, and barley. Oats may also contain gluten. It is estimated that about 2 million people in the United States have celiac disease, or about 1 in 133 people, however, only about 3% have been diagnosed. The incidence the disease is further increased among people who have a first-degree relative diagnosed with celiac disease. In such cases, as many as 1 in 22 people may have the disease.

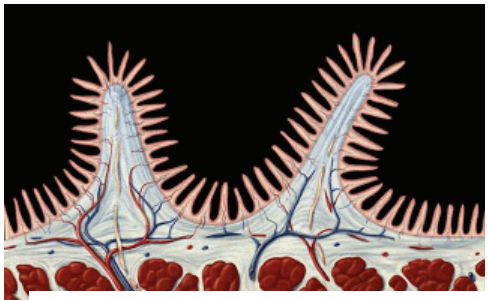


The Human Digestive System

of

GENERAL INFORMATION

Celiac disease is also known as celiac sprue, nontropical sprue, and gluten-sensitive enteropathy. The disease affects the small intestine. When individuals suffering from celiac disease consume products containing gluten such as bread, pasta, cake, cookies, and some multivitamins, and medications, their immune system responds by damaging or destroying the villi located within the small intestine. Villi are fingerlike projections located on the folds of the small intestine that aid in the absorption of certain nutrients. The condition can result in the malabsorption of fat, protein, carbohydrate, vitamin K, folate, vitamin B12, iron, and calcium. Lactose intolerance is also common.


Normal small intestine lining covered by villi which are destroyed by inflammation in celiac disease.

Although gluten is often considered the contributing component in foods that cause the damage to the small intestine, it is actually a general term for the storage proteins found in grains. The proteins of concern for those with celiac disease are gliadin in wheat, secalin in rye, hordein in barley, and avenin in oats. These grains contain certain amino acid sequences and are particularly rich in the amino acids proline and glutamine. The amino acid sequences cannot be broken down or absorbed by a person with celiac disease.

CONSEQUENCES OF UNTREATED CELIAC DISEASE

Symptoms of celiac disease may include one or more of the following:

- Irritability or depression
- Weight loss/ weight gain
- Diarrhea
- Abdominal cramps, gas and bloating
- General weakness
- Foul-smelling or fatty stools
- Unexplained anemia (a low count of red blood cells causing fatigue)
- Bone or joint pain
- Muscle cramps
- Tingling numbness in the legs (from nerve damage)
- Stunted growth (in children)
- Osteoporosis
- Dermatitis herpetiformis (skin lesions)

DIAGNOSING CELIAC DISEASE

There are generally three steps in diagnosing celiac disease. First, because people with celiac disease have higher levels of certain antibodies in their blood stream, a blood test is performed. The blood test should detect elevated levels of the particular antibodies associated with celiac disease. The second step is to confirm the blood test. A physician will perform a biopsy. This is done by inserting a thin flexible tube into the mouth of the patient which is past into the small intestine. A small tissue sample is collected and examined for damaged villi. If the results are positive, the third step is to look for improvement while following a gluten-free diet.

LIVING WITH CELIAC DISEASE

Currently, there is not a cure for celiac disease; however, the prognosis for children with celiac disease is very good. Once a person is diagnosed and begins to adhere to a gluten-free diet, they should begin noticing an improvement almost immediately. After a few weeks or months the intestinal damage is almost completely reversed.

DIETARY REQUIREMENTS

The goal of a gluten-free diet is to eliminate all foods that contain wheat, rye, and barley. Other grains that should be eliminated are oats, triticale, spelt, and kamut. Some research indicates that oats may be acceptable; however, this should be determined by a physician on a case by case basis.

Great care should be taken when preparing and storing foods for people with celiac disease. Avoid contaminating the foods they eat with bread crumbs from toasters, cutting boards, grills, or those that may be in margarine or jelly or in fats used to fry foods.

The following chart can help determine what foods should and should not be consumed if a child is on a Gluten-Free Diet. The chart is for reference only; all foods should be approved by a physician.

RECOMMENDED FOODS	FOODS TO AVOID
• Breads or bread products made from corn, rice, soy, arrowroot corn or potato starch, pea, potato or whole-bean flour, tapioca, sago, rice bran, cornmeal, buckwheat, millet, flax, teff, sorghum, amaranth, and quinoa • Hot cereals made from soy, hominy, hominy grits, brown and white rice, buckwheat groats, millet, cornmeal, and quinoa flakes • Puffed corn, rice or millet, and other rice and corn made with allowed ingredients • Rice, rice noodles, and pastas made from allowed ingredients • Some rice crackers and cakes, popped corn cakes made from allowed ingredients	• Breads and baked products containing wheat, rye, triticale, barley, oats, wheat germ or bran, graham, gluten or durum flour, wheat starch, oat bran, bulgur, farina, wheat-based semolina, spelt, kamut • Cereals made from wheat, rye, triticale, barley, and oats; cereals with added malt extract and malt flavorings • Pastas made from ingredients above • Most crackers
• All milk and milk products except those made with gluten additives • Aged cheese	• Malted milk • Some milk drinks, flavored or frozen yogurt
• All plain, fresh, frozen, or canned vegetables made with allowed ingredients	• Any creamed or breaded vegetables (unless non-allowed ingredients are used), canned baked beans • Some french fries
• All fruits and fruit juices	• Some commercial fruit pie fillings and dried fruit
• All meat, poultry, fish, and shellfish; eggs • Dry peas and beans, nuts, peanut butter, soybeans • Cold cuts, frankfurters, or sausage without fillers	• Any meat, poultry, fish or shellfish prepared with wheat, rye, oats, barley, gluten stabilizers, or fillers including some frankfurters, cold cuts, sandwich spreads, sausages, and canned meats • Self-basting turkey • Some egg substitutes
• Butter, margarine, salad dressings, sauces, soups, and desserts made with allowed ingredients • Sugar, honey, jelly, jam, hard candy, plain chocolate, coconut, molasses, marshmallows, meringues • Pure instant or ground coffee, tea, carbonated drinks, wine (made in U.S.), rum, alcohol distilled from cereals such as gin, vodka, and whiskey • Most seasonings and flavorings	• Commercial salad dressings, prepared soups, condiments, sauces and seasonings prepared with ingredients listed above • Hot cocoa mixes, nondairy cream substitutes, flavored instant coffee, herbal tea, and beer • Beer, ale, cereal, and malted beverages • Licorice

MANAGING CELIAC DISEASE IN A SCHOOL FOOD SERVICE SETTING

Once a child with celiac disease reaches school-age, Local Educational Agencies in accordance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, are required to accommodate the special dietary needs of the child. However, a written physician's order is required which should include a description of the disability, an explanation for how the disability affects the diet, the dietary changes required, and offers suggested menu modifications. Although gluten-free products may be more expensive, the school is not allowed to charge the student any more than the current price of the regular breakfast or lunch. When possible, try to offer the student foods that are similar to what is on the standard menu. This may help prevent the student from feeling different from other students.

RESOURCES

Celiac Foundation: **www.celiac.org**
Mayo Clinic: **www.mayoclinic.com/invoke.cfm?id=DS00319**
Celiac Sprue Association: **www.csaceliacs.org/celiac_defined.php**

Gluten-Free Product Resources

Celiac Disease and Gluten-Free Resource: **www.celiac.com/st_main.html?p_catid=19**
The Gluten-Free Mall: **www.glutenfreemall.com/**

NON DISABLED CHILDREN

DEFINITION

The school food service **may make food substitutions, at their discretion**, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Such determinations are only made on a case-by-case basis. This provision covers those children who have food intolerances or allergies but do not have life-threatening reactions (anaphylactic reactions) when exposed to the food(s) to which they have problems.

MEDICAL STATEMENT FOR CHILDREN WITH SPECIAL DIETARY NEEDS

Each special dietary request must be supported by a statement, which explains the food substitution that is requested. It must be signed by a recognized medical authority.
The medical statement must include:

- An identification of the medical or other special dietary condition which restricts the child's diet;
- The food or foods to be omitted from the child's diet; and
- The food or choice of foods to be substituted.

CHILDREN WITH OTHER SPECIAL DIETARY NEEDS

Sponsors of child nutrition programs may, **at their discretion**, make substitutions for individuals who are not disabled as defined in 7 CFR 15b.3 (i), but who are unable to consume a food item because of medical or other special dietary needs. Such substitutions may be made only on a case-by-case basis and when supported by a statement signed by "a recognized medical authority." In such cases, "recognized medical authority" includes a Naturopathic or Osteopathic physician, Registered Nurse, Registered Dietician, Nurse Practitioner or other professionals specified by the State agency.
For those non-disabled participants, the supporting statement shall include:

- The identification of the medical or other special dietary needs which restricts the child's diet
- The food or foods to be omitted
- The food or choice of foods that may be substituted

In most cases, individuals who are overweight or who have elevated blood cholesterol do not meet the definition of disabled, and sponsors are not required to make meal substitutions for them. The special dietary need of non-disabled participants may be managed within the normal program meal service when a well-planned variety of nutritious foods are available and when Offer Versus Serve is an option.

Contact a School Health and Nutrition Program specialist for additional information (602) 542-8700
Additional Forms may be downloaded from the Arizona Department of Education Website at: **http://www.azed.gov/health-nutrition/nslp/**

MEDICAL STATEMENT
FOR
PARTICIPANTS WITH ALLERGIES/CHRONIC DISEASES

Other medical personnel may complete this form (dietitian, speech pathologist, occupational therapist), but a physician or other recognized medical authority must sign in agreement as to what is written. For purposes of this program, a "recognized medical authority" means a Naturopathic or Osteopathic physician, Registered Nurse, Registered Dietician, Nurse Practitioner or other professionals specified by the State agency.
.

Name of Participant	Age	School	Grade
Parent Name	Telephone	Additional information	

Food Allergy/Chronic Disease:

_____
_____
_____
_____
_____
_____

Foods to be Omitted and Substitutions: (Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.)

Foods to be Omitted	**Suggested Substitutions**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Preparer/Title	Printed Name	Telephone	Date
Signature of Recognized Medical Authority/Title	Printed Name	Telephone	Date

LACTOSE INTOLERANCE

OVERVIEW

Lactose intolerance is a condition resulting from lactose maldigestion. The condition occurs when a person is unable or has a decreased ability to digest lactose due to lack of an enzyme. Lactose is a sugar found in milk and dairy products. Individuals with lactose intolerance often experience abdominal discomfort when consuming dairy products. It is estimated that 30 to 50 million Americans are lactose intolerant. Certain ethnic and racial populations are more widely affected than others. About 90% of Asian-Americans and as many as 75% of African-Americans, Hispanic-Americans, Jewish and Native-Americans are lactose intolerant.

GENERAL INFORMATION

Lactose maldigestion is defined as a decrease in the level of or activity of the enzyme lactase. The lactase enzyme is found in the small intestine. Lactase acts to split the lactose sugar into two sugars known as glucose and galactose. Galactose is then converted to glucose which is the energy source of our body cells.

If inadequate amount of lactase is being produced in the small intestine, proper digestion of lactose will not occur. The undigested lactose passes through the small intestine and enters the large intestine. Bacteria present in the large intestine will break down the lactose producing acids and gas; this will result in abdominal discomfort. Individuals who experience lactose maldigestion are not allergic to milk or dairy products. Since a lactose intolerance is not a milk allergy, there are no detrimental or life threatening effects. A milk allergy is associated with the protein found in milk, not lactose.

CONSEQUENCES OF UNTREATED LACTOSE INTOLERANCE

The severity of symptoms varies greatly among individuals with lactose intolerance. Symptoms of lactose intolerance may include one or more of the following:

- Bloating
- Cramping
- Diarrhea
- Flatulence
- Lower Back Pain
- Nausea

DIAGNOSING LACTOSE INTOLERANCE

There are several procedures that can be used to diagnose lactose intolerance. The procedures include the lactose tolerance test, the hydrogen breath test, and the stool acidity test.

The most common test is the hydrogen breath test. Normally, hydrogen gas is not detected in the breath. However, someone maldigesting lactose will exhale hydrogen due to the breakdown of lactose by intestinal bacteria located in the large intestine. The hydrogen is absorbed from the intestines, carried through the bloodstream to the lungs, and exhaled. In the test, the individual will blow into a tube to collect baseline data. The person will then consume a drink containing lactose and after about thirty minutes will blow into a tube for a second time. The hydrogen level is then checked. A positive test for hydrogen indicates lactose malabsorption.

Treatment varies among individuals as tolerance may change over time. Some individuals find that introducing small amounts of lactose into their diet slowly increases their tolerance of foods containing lactose.

The lactose tolerance test is appropriate for older children and adults. A blood test is first taken to measure the level of glucose in the blood. The person then consumes a liquid containing a large amount of lactose. Blood tests are then taken during following two hours and measured for glucose level. During proper digestion, the enzyme lactase will breakdown lactose into glucose and galactose. An increase in blood glucose will then be indicated in the follow-up blood tests. If there is no increase in blood glucose, lactose intolerance in confirmed.

The third test is the stool acidity test, which measures the amount of acid in the stool. Acid is produced when lactose is passed undigested into the large intestine. The intestinal bacteria will then breakdown the lactose creating acids and gas. If the stool sample contains acids, lactose intolerance is indicated.

LIVING WITH LACTOSE INTOLERANCE

The body does not require lactose in order to be healthy. Lactose intolerance may result in discomfort, however generally it is not life threatening. An exception may be an infant suffering from diarrhea due to lactose intolerance. The diarrhea may result in dehydration which can lead to other complications.

DIETARY REQUIREMENTS

Managing lactose intolerance will require some dietary changes. However, removing all dairy products from the diet is usually not necessary. Lactose intolerance is very individualized; most people can still consume a limited amount of milk and other dairy products. Eliminating dairy products from the diet and then slowly reintroducing small amounts while monitoring for symptoms will help determine lactose sensitivity.

For people who need to eliminate all dairy products it is important to find other good sources of calcium, riboflavin, and vitamin D. Adequate calcium intake is especially important for proper bone development. A diet void of lactose can be difficult because lactose is found not only in dairy products but also as an ingredient in nondairy foods such as bread, cereals, breakfast drinks, salad dressing, and cake mixes. Reading food ingredient labels is important for someone following a strict lactose-free diet. Foods containing milk, milk solids, whey, and casein should be avoided. It is also important to check the ingredients of medications and vitamins because many contain lactose as filler.

MANAGING LACTOSE INTOLERANCE IN A SCHOOL FOOD SERVICE SETTING

Lactose intolerance is not considered a disability but rather a medical or special dietary need. Schools may substitute non-dairy beverages nutritionally equivalent to fluid milk for students who cannot consume fluid milk because of a medical or other special dietary need. Substitution for non-disabled students is optional. Memo CN# 33-11 lists allowable varieties of milk that may be substituted including, but not limited to, fat-free or low-fat lactose reduced milk and fat-free or low-fat lactose-free milk. In order for the substitution to be considered part of a reimbursable meal, the LEA must receive a written statement from a medical authority or the student's parent or legal guardian that identifies the medical or other special dietary need. The LEA reserves the right to limit the available substitutions.

Although lactose free products may be more expensive, the school is not allowed to charge the student any more than the current price of the regular breakfast or lunch. Any expenses not covered by program reimbursements must be paid by the school district.

RESOURCES

National Institute of Diabetes and Digestive and Kidney Disease
digestive.niddk.nih.gov/ddiseases/pubs/lactoseintolerance/

Medline Plus
www.nlm.nih.gov/medlineplus/lactoseintolerance.html

FOOD ALLERGY OR INTOLERANCE

REQUIREMENTS IN NATIONAL SCHOOL LUNCH PROGRAM/FOODSERVICE

Generally, students with food allergies or intolerances, or obese students are **not** "disabled persons", as defined in 7 CFR 15b.3(i), and school food authorities are **not** required to make substitutions for them. **However**, when in the licensed physician's assessment, food allergies may result in severe, life-threatening (anaphylactic) reactions or the obesity is severe enough to substantially limit a major life activity, the student's condition would meet the definition of "disabled person," and the **food service personnel must make the substitutions prescribed by the physician.**

OVERVIEW

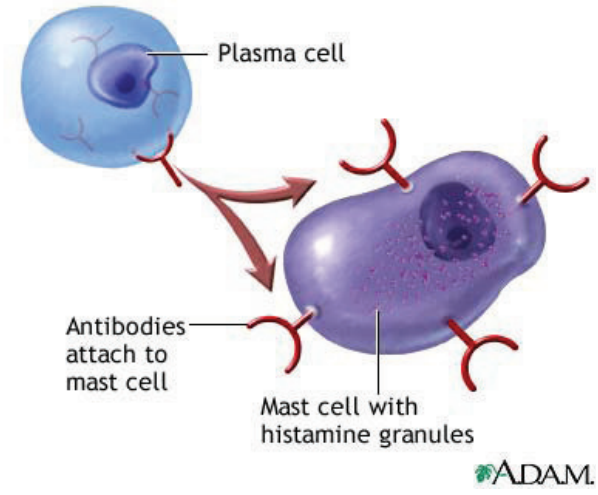
- 11 million people in the United States suffer from food allergies.
- 150 to 200 people die every year of severe reactions to food allergies.
- 30,000 emergency room visits are the result of severe food allergy reactions each year.

GENERAL INFORMATION

The most common food allergens that cause problems in children are eggs, milk, peanuts, soy, and wheat. Adults usually do not lose their allergies, but children can sometimes outgrow them. Children are more likely to outgrow allergies to milk or soy than allergies to peanuts, fish, or shrimp.

HOW ALLERGIC REACTIONS WORK

An allergic reaction often involves the production of immunoglobulin E (IgE), an antibody that circulates through the blood. The ability of a given individual to form IgE against something as benign as food is an inherited predisposition. Generally, such people come from families in which allergies are common -- not necessarily food allergies but perhaps hay fever, asthma, or hives. Someone with two allergic parents is more likely to develop food allergies than someone with one allergic parent.



Before an allergic reaction can occur, a person who is predisposed to form IgE to foods first has to be exposed to the food. As this food is digested, it triggers certain cells to produce specific IgE in large amounts. The IgE is then released and attaches to the surface of mast cells. These cells occur in

all body tissues but are especially common in areas of the body that are typical sites of allergic reactions, including the nose and throat, lungs, skin, and gastrointestinal tract.

The next time the person eats that food, it interacts with specific IgE on the surface of the mast cells and triggers the cells to release chemicals such as histamine. Depending upon the tissue in which they are released, these chemicals will cause a person to have various symptoms of food allergy. If the mast cells release chemicals in the ears, nose, and throat, a person may feel an itching in the mouth and may have trouble breathing or swallowing. If the affected mast cells are in the gastrointestinal tract, the person may have abdominal pain or diarrhea. The chemicals released by skin mast cells, in contrast, can prompt hives.

Food allergens (the food fragments responsible for an allergic reaction) are proteins within the food that usually are not broken down by the heat of cooking or by stomach acids or enzymes that digest food. As a result, they survive to cross the gastrointestinal lining, enter the bloodstream, and go to target organs, causing allergic reactions throughout the body.

The complex process of digestion affects the timing and the location of a reaction. If people are allergic to a particular food, for example, they may first experience itching in the mouth as they start to eat the food. After the food is digested in the stomach, abdominal symptoms such as vomiting, diarrhea, or pain may start. When the food allergens enter and travel through the bloodstream, they can cause a drop in blood pressure. As the allergens reach the skin, they can induce hives or eczema, or when they reach the lungs, they may cause asthma.

Source: **www.drgreene.com/ 21_1295.html**

CONSEQUENCES OF UNTREATED FOOD ALLERGY OR INTOLERANCE

Common symptoms and signs of allergic reactions may be a combination of any of the following:

- Hives
- Itching (of any part of the body)
- Swelling (of any body parts)
- Red, watery eyes
- Runny nose
- Vomiting
- Diarrhea
- Stomach cramps
- Change of voice
- Coughing
- Wheezing
- Throat tightness or closing
- Difficulty swallowing
- Difficulty breathing
- Sense of doom
- Dizziness
- Fainting or loss of consciousness
- Change of color

DIAGNOSING FOOD ALLERGY OR INTOLERANCE

A diet history and or food diary can help pinpoint problem foods. The most common method to pinpoint the food allergy is the use of the elimination diet. The food in question is removed from the diet, if the symptoms go away and return with the reintroduction of the previously removed food, then the diagnosis may be confirmed. Skin tests and blood tests are also methods used to determine food allergens.

LIVING WITH FOOD ALLERGY OR INTOLERANCE

Food allergy is treated by avoiding the problem foods. Once a patient and doctor have identified the food to which the patient is sensitive, the food must be removed from the patient's diet. Eliminating the problem foods has become much easier since the Food Allergen Labeling and Consumer Protection Act (FALCPA) went into effect in January 2006. This law requires manufactures to clearly label any food that contains one of the eight major food allergens; milk, eggs, fish, shellfish, nuts, wheat, peanuts and soybeans.

Managing Food Allergies in the Cafeteria
Tips for Food Service Staff

Eating in the school cafeteria is often stressful for young students with food allergies. Hidden ingredients, cross contact between foods, and the fear of allergens left on lunch tables are often a cause for concern.

Feeding a child with food allergies can be just as stressful. When you consider the additional challenge of juggling many diet-related conditions among your student body, it's easy to see how your food service staff can become overwhelmed.

The food service staff plays an important role in your food allergy management team, and they should attend all meetings on the topic. The following are some guidelines for key staff members.

Know what to avoid and substitute. Ask the parents of each student with a food allergy to provide a list of all food ingredients to be avoided. Do not rely on lists of "safe" prepackaged food because ingredients can change often and without warning, making such lists out-of-date quickly.

Read labels. Develop a system for checking ingredient labels carefully for every food item to be served to the student with the allergy. One student who was allergic to legumes (such as beans, soy, and peanuts) had an allergic reaction after eating cheese pizza she had purchased in the school cafeteria. The reaction was caused by dried navy beans, which the manufacturer had added to the crust to increase the protein to meet nutritional standards. Although beans were listed on the ingredient label, nobody expected them to be used in this type of food product.

Prepare the kitchen. Designate an area in the kitchen where allergy-free meals can be prepared. This area should be a "safe zone" and kept free of ingredients allergic students should avoid.

Identify the student. When working with younger children, consider how students with food allergies will be identified when moving through the cafeteria line so that someone can ensure the selected food is safe. Some schools require that these students identify themselves to food service staff; others specially code lunch tickets as a way of alerting staff to a food allergy. One school identified a student with an allergy by taping his picture to the cash register.

Develop cleaning procedures. Designate a person to be responsible for ensuring that lunch tables and surrounding areas are thoroughly cleaned before and after lunch. Use a designated sponge or cleaning cloth for the allergy-free tables to avoid cross contact.

Finally, it's the school's responsibility to serve the food; it is the parents' responsibility to teach you what their child can or cannot eat. Don't hesitate to ask questions. Success is achieved by working in partnership with the child's parents and the student who has food allergies.

Reprinted from Food Allergy News Special Issue for Elementary School Principals, Spring 2002.

RESOURCES

SCHOOL GUIDELINES FOR MANAGING STUDENTS WITH FOOD ALLERGIES
www.foodallergy.org/school/SchoolGuidelines.pdf

FOOD ALLERGY AND ANAPHYLAXIS NETWORK
www.foodallergy.org/school.html

FOOD ALLERGY, AN OVERVIEW
www.niaid.nih.gov/publications/pdf/foodallergy.pdf

AMERICAN ACADEMY OF ALLERGY, ASTHMA, AND IMMUNOLOGY
611 East Wells Street
Milwaukee, WI 53202
Phone: 414-272-6071
Patient Information and Physician Referral Line: 1-800-822-2762
For all general questions, e-mail: info@aaaai.org
Web: **www.aaaai.org**

CHILDREN WITH RELIGIOUS/ETHNIC DIETARY NEEDS

School food authorities are **not required** to accommodate student and family dietary choices based on ethnic, cultural, or religious preference. However, it is recommended that the school food authority accommodate these requests whenever feasible.

DEFINITION

The population of students attending public schools is becoming increasingly diverse. It is estimated that one-third of the population is made up of minority ethnic and faith communities. Section 210.10 of the Code of Federal Regulations (CFR) states that schools **should consider** ethnic and religious preferences when planning and preparing meals. Any variations must comply with meal pattern regulations while meeting ethnic, religious or economic needs.

DIETARY REQUIREMENTS

Many faith and ethnic minority students observe specific dietary restrictions. While individuals of Muslims and Jewish decent do not allow for the consumption of pork, Hindus and Seventh-Day Adventists follow a vegetarian diet. In order to meet the needs of these specific children, a few school districts have created policies and procedures that recognize and accommodate these students.

The Chicago Public School System created a policy to accommodate religious diversity in dietary requirements:

"The Board of Education recognizes the multicultural and multi-religious composition of the student population in the Chicago Public Schools. Some children, because of religious restrictions, are prohibited from eating pork and certain other foods. If an alternative entrée is not available, these children will be unable to benefit from all food components of the meals served at school. Therefore, an alternative entrée must be offered when such foods are served for school meals."

This policy from the Board of Education mandates that schools MUST provide a student with an alternate selection when dietary restrictions apply. Another school district, Fairfax County Public Schools, has adopted a policy which puts the responsibility more upon the parents.

"Nothing in this instruction is meant to require schools, institutions, and sponsors to operate special diet kitchens. Usually there is no difficulty acquiring substitute items in local markets. However, if the authorized substitute foods are not normally kept in inventory or are not generally available in local markets, the parent or guardian should provide the substitute food item(s) prescribed by the physician or recognized authority…Post "Pork Pig" sign if pork is on menu."[1]

Each school district has local control over deciding how they will approach accommodating students with special dietary needs due to ethnic or religious restrictions. The following pages provide specific information on some of the more common religious groups affected by the school foodservice profession. ***The religious groups detailed are not an all inclusive list.***

(Sample menus are included with suggested substitutions. Please note that these are examples only; all menus must follow the meal pattern with appropriate meal components served in appropriate portion sizes.)**

MUSLIM

DIETARY REQUIREMENTS

Muslim dietary laws provide a set of rules as to what is allowable in their diet. These rules come from the holy book of Islam, the Qur'an. The law prohibits Muslims from eating pork or any pork products such as lard, ham and pepperoni. These ancient dietary restrictions may have evolved over time to prevent trichinosis, which is caused by eating undercooked pork. Blood is also prohibited. Raw meat must be soaked in water to drain out the blood before cooking. Meat that is "well done", having no trace of blood, may be consumed.

CALENDAR OF EVENTS

The six most important Islamic Holy Days are Ashura, Mawlid, Ramadan, Id al-Fitr and Id al-Adha. All dates are approximate, because they depend upon the method of determining the timing of a New Moon.

Descriptions of the Holy Days:

- *Al-Hijra/Muharram* is the Muslim New Year, the beginning of the first lunar month.
- *'Ashura* recalls an event circa 680-OCT-20 in Iraq when an army of the Umayyad regime martyred a group of 70 individuals who refused to submit to the Caliph. One of the martyrs was Imam Husain, the youngest grandson of Prophet Muhammad.
- *Mawlid al-Nabi* is a celebration of the birthday of the Prophet Muhammad, the founder of Islam in 570 CE.
- *Ramadan* is the holiest period in the Islamic year; it is held during the entire 9th lunar month of the year. This was the month in which the Qura'n was revealed to the Prophet Muhammad. The first day of Ramadan is listed above. It is a time at which almost all Muslims over the age of 12 are expected to fast from sunup to sundown, unless they suffer from health problems which would make fasting dangerous.
- *Id al-Fitr* (a.k.a. "*Id*" and "*Eid*") is the first day of the 10th month -- i.e. the day after the end of Ramadan. It is a time of rejoicing. Houses are decorated; Muslims buy gifts for relatives.
- *Id al-Adha* (a.k.a. the *Feast of Sacrifice* or *Day of Sacrifice*) occurs during the 12th month of the Islamic year. It recalls the day when Abraham intended to follow the instructions of God, and sacrifice his son Ishmael.

****SAMPLE MENU FOR ACCOMMODATING MUSLIM DIETARY RESTRICTIONS**

Day	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Regular Menu	Corn Dog Oven Fries Carrot Sticks Whole-Wheat Roll Milk	Pepperoni Pizza Garden salad Pears Milk	Ham and Cheese Sandwich Carrot Sticks Apple Milk	Ham Baked potato Broccoli Applesauce Wheat bread Milk	Navy Bean Soup (made with ham bone) Dinner Roll Peaches Green Beans Milk
Accommodating Menu	**Turkey Corn Dog** Oven Fries Carrot Sticks Whole-Wheat Roll Milk Mustard	**Cheese Pizza** Garden Salad Pears Milk	**Turkey and Cheese Sandwich** Carrot Sticks Apple Milk	**Salisbury Steak** Baked Potato Broccoli Applesauce Wheat Bread Milk	**Navy Bean Soup (vegetarian)** Dinner Roll Peaches Green Beans Milk

JEWISH

DIETARY REQUIREMENTS
Dairy and meat are not to be eaten, served or cooked together according to Jewish dietary restrictions, because it is considered to be unhealthy. Pork and shell fish are not permitted. All blood must be drained from meat and poultry before cooking. In order to be considered Kosher, all meat must be processed with the approval of a Rabbi.

Descriptions of the holy days:

SHABBAT (THE SABBATH)
Begins every Friday at sunset and ends Saturday at nightfall. Shabbat is one of the most sacred days of the Jewish calendar, observed by prayer and study.

PURIM (FESTIVAL OF LOTS)
The Megillah (scroll) of Esther is read amidst joyous celebration and the wearing of costumes in the festival celebrating the defeat of Haman, the enemy of the Jews, in ancient Persia.

PASSOVER (PESACH)
Passover celebrates the story of the Exodus of the Israelites from Egyptian bondage. The Seder service at home on the first two nights recounts this story. Celebration lasts eight days.

SHAVUOT (FEAST OF WEEKS)
Shavuot commemorates the giving of the Torah (the law) at Mount Sinai.

ROSH HASHANAH (NEW YEAR)
Rosh Hashanah begins the ten days of repentance. The shofar (ram's horn) is blown as part of the Synagogue service.

YOM KIPPUR (DAY OF ATONEMENT)
Yom Kippur is the holiest day of the Jewish calendar, observed by fasting and continuous prayer throughout the day asking for atonement for sins committed throughout the previous year.

SUKKOT (FESTIVAL OF BOOTHS)
Sukkot is a harvest festival; it recalls the dwelling of the Israelites in booths as they wandered in the desert after escaping from Egypt.

SHIMINI ATZERET (8TH DAY OF ASSEMBLY)
The Synagogue service includes the Tefillat Geshem, a prayer for rain.

SIMCHAT TORAH (REJOICING OF THE LAW)
The final verses of the Torah in Deuteronomy are read and then immediately the opening verses of Genesis are also read signifying the continuity of the Torah in Jewish life.

HANUKKAH (FESTIVAL OF LIGHTS)
Hanukkah celebrates freedom of religion. Recapturing the Temple from the Greek Syrians, the Macabees lit a cruse of oil which remains lit for eight days. Candle lighting on each of eight nights recalls these events.

****SAMPLE MENU FOR ACCOMMODATING JEWISH DIETARY RESTRICTIONS**

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Regular menu	Beef and Cheese Burrito Spanish Rice Corn Pears Milk	Pepperoni Pizza Garden Salad Orange Slices Milk	Ham and Cheese Sandwich Carrot sticks Apple Milk	Ham Baked potato Broccoli Applesauce Wheat bread Milk	Navy Bean Soup (made with ham bone) Dinner roll Peaches Green beans Milk
Accommodating menu	**Bean and Cheese Burrito** Spanish Rice Corn Pears Milk	**Cheese Pizza** Garden salad Orange Slices Milk	***Kosher Turkey Sandwich** Carrot sticks Apple *Milk	***Kosher Chicken** Baked potato Broccoli Applesauce Wheat bread *Milk	**Navy Bean Soup (vegetarian)** Dinner roll Peaches Green beans Milk

*** Dairy and meat are not to be eaten, served or cooked together according to Jewish dietary restrictions, because it is considered to be unhealthy. Offer versus Serve would be an option for these menus; a student would be able to turn down either the meat or milk and be in compliance with the dietary restrictions. Another option would be to change the Turkey Sandwich and Chicken for vegetarian choices.**

SEVENTH DAY ADVENTIST

DIETARY REQUIREMENTS

Members follow a well balanced vegetarian diet. An emphasis on total health is stressed by followers of this religion. If meat and/or fish are taken, they must be kosher. In this matter, the diet follows the restrictions and regulations of a Jewish diet.

****SAMPLE MENU FOR ACCOMMODATING SEVENTH DAY ADVENTIST DIETARY RESTRICTIONS**

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Regular menu	Beef and Cheese Burrito Spanish Rice Corn Pears Milk	Pepperoni Pizza Garden salad Orange Slices Milk	Ham and Cheese Sandwich Tomato Soup Apple Milk	Ham Baked potato Broccoli Applesauce Wheat bread Milk	Navy Bean Soup (made with ham bone) Dinner roll Peaches Green beans Milk
Accommodating menu	**Bean and Cheese Burrito** Spanish Rice Corn Pears Milk	**Cheese Pizza** Garden salad Oranges Slices Milk	**Grilled Cheese Sandwich** Tomato Soup Apple Milk	**Baked Potato w/ Broccoli and Cheese** Applesauce Wheat bread Milk	**Navy Bean Soup (vegetarian)** Dinner roll Peaches Green beans Milk

CATHOLICISM

DIETARY REQUIREMENTS

There are no specific dietary laws in Catholicism except during the period of Lent. Lent begins with Ash Wednesday and ends on Easter Sunday. During Lent, practicing Catholics observe the laws of abstinence. This means they are not allowed to consume any meat on Fridays. Fish and other seafood, however, are acceptable.

CALENDAR OF EVENTS THAT IMPACT MEAL SERVICE

Current fasting practice in the Catholic Church binds persons over the age of seventeen and younger than sixty. On Ash Wednesday and Good Friday, one eats only one full meal, but may eat two smaller meals as necessary to keep up strength. The two small meals together must sum to less than the one full meal. Parallel to the fasting laws are the laws of abstinence. These bind those over the age of twelve. On days of abstinence, the Catholic must not eat meat or poultry. According to Canon Law, all Fridays of the year and Ash Wednesday are days of abstinence, though in most countries, the strict requirement of abstinence has been limited by the Bishops to the Fridays of Lent and Ash Wednesday. On other abstinence days, the faithful are invited to perform some other act of penance.

Fasting during Lent was in ancient times more severe than it is today. Meat, fish, eggs and milk products were strictly forbidden, and only one meal was taken each day. Today, in the West, the practice is considerably relaxed, though in the Eastern church, abstinence from the above mentioned food products is still commonly practiced. Lenten practices (as well as other liturgical practices) are more common in Protestant circles than they once were.

****SAMPLE MENU FOR ACCOMMODATING CATHOLIC DIETARY RESTRICTIONS (DURING LENT)**

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Regular menu	Corn dog Oven Fries Carrot Sticks Whole-Wheat Roll Milk	Pepperoni Pizza Garden salad Pears Milk	Ham and Cheese Sandwich Carrot sticks Applesauce Milk	Ham Rice Broccoli Orange Slices Wheat bread Milk	Navy Bean Soup (made with ham bone) Dinner Roll Peaches Green beans Milk
Accommodating menu	**No changes needed**	**No changes needed**	**No changes needed**	**No changes needed**	**Navy Bean Soup (vegetarian)** Dinner Roll Peaches Green beans Milk

GLOSSARY

AMERICANS WITH DISABILITIES ACT (ADA)

Comprehensive legislation, signed into law on July 26, 1990, that creates new rights and extends existing rights for Americans with disabilities. Title II of the Act is especially significant for the school nutrition programs, as it requires equal availability and accessibility in State and local government programs and services, including public schools.

ANAPHYLAXIS/ANAPHYLACTIC REACTION

Anaphylaxis is a rare but potentially fatal condition in which several different parts of the body experience food-allergic reactions at the same time. Symptoms may progress rapidly and include severe itching, hives, sweating, swelling of the throat, breathing difficulties, lowered blood pressure, unconsciousness and even death. Students with Anaphylaxis carry, and self-administer, emergency medications.

***SB1309 Signed 5/11/05 Requires school districts to adopt and enforce policies and procedures to allow pupils who have been diagnosed with anaphylaxis to carry and self-administer emergency medications while at school and school-sponsored activities. Additionally, school districts and employees are immune from civil liability for all decisions made and actions taken in good faith to implement these provisions.**

DISABILITY

Under Section 504 of the *Rehabilitation Act of 1973* and the *Americans with Disabilities Act*, "person with a disability" refers to any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of impairment, or is regarded as having such impairment. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; metabolic diseases such as diabetes and phenylketonuria (PKU); food anaphylaxis; mental retardation; emotional illness; and drug addiction and alcoholism. Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

Under the *Individuals with Disabilities Education Act* (IDEA), the term "disability" refers to specified physical, mental, emotional, or sense impairments, which adversely affect a child's educational performance. Thirteen recognized disability categories, which establish a child's need for special education and related services, are listed in IDEA. These disabilities include autism; deaf-blindness; deafness or other hearing impairments; mental retardation; orthopedic impairments; other health impairments due to acute health problems (such as a heart condition, epilepsy, or tuberculosis); emotional disturbance; specific learning disabilities; speech or language impairment; traumatic brain injury; visual impairment, including blindness, which adversely affects a child's educational performance.

FOOD ALLERGY

A food allergy is a hypersensitivity from an abnormal response of the body's immune system to food or food additives that would otherwise be considered harmless. Many of the true food allergy symptoms often resemble allergic reactions to other substances, such as penicillin, drugs, bee stings, hives and itching.

FOOD INTOLERANCE
Food intolerance is an adverse food-induced reaction that does not involve the body's immune system. Lactose intolerance is one example of a food intolerance. A person with lactose intolerance lacks an enzyme that is needed to digest milk sugar. When milk products are consumed symptoms such as gas, bloating, and abdominal pain may occur.

FREE APPROPRIATE PUBLIC EDUCATION (FAPE)
Under the *Individuals with Disabilities Education Act ,* FAPE means special education and related services provided under public supervision and direction, in conformity with an individualized education program (IEP), and at no cost to parents. In appropriate situations, nutrition services could be deemed "special education" (specially designed instruction) or a "related service" (support services required to assist a child with a disability to benefit from special education).

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)
Formerly the *Education of the Handicapped Act*, originally enacted in 1975, IDEA includes Part B, the basic grants to States program, which provides Federal funds to assist States and school districts in making a free appropriate public education available to eligible students with specified disabilities.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)
The Individualized Education Program or IEP means a written statement for a child with a disability that is developed, reviewed, and revised in a meeting in accordance with the IDEA and its implementing regulations. The IEP is the cornerstone of the student's educational program that contains the program of special education and related services to be provided to a child with a disability covered under the IDEA.

NOTE: Some states supplement the IEP with a written statement specifically designed to address a student's nutritional needs. Other states employ a "Health Care Plan" to address the nutritional needs of their students. For ease of reference the term "IEP" is used to reflect the IEP as well as any written statement designating the required nutrition services.

OSTEOPATHIC PHYSICIAN OR DOCTOR OF OSTEOPATHIC MEDICINE
A fully trained physician, who is licensed by the State to prescribe medication or to perform surgery. The American Medical Association includes osteopathic physicians as equal members with M.D.s. The majority of doctors of osteopathic medicine are primary care physicians.

RECOGNIZED MEDICAL AUTHORITY
Physicians, physician assistants, nurse practitioners; or other professionals specified by the State agency. See *FNS Instruction 783-2, Revision 2, Meal Substitutions for Medical or Other Special Dietary Reasons*.

REGISTERED DIETITIAN R.D.
A nutrition professional, who has earned a B.S. or B.A. degree, met basic academic and clinical training requirements, completed an accredited dietetic internship, and passed the qualifying examination for professional registration for dietetics. The registration program is maintained by the Commission on Dietetic Registration of the American Dietetic Association. R.D.s can answer questions on special diets, menu planning, and related topics and conduct a nutritional assessment. An R.D. may work with the physician and school staff to assist in meeting a child's special nutritional needs and to ensure that menus are in compliance with the physician's diet order.

SCHOOL NURSE

It is the position of the National Association of School Nurses that the registered professional school nurse is the leader in the school community to oversee school health policies and programs. The school nurse serves in a pivotal role to provide expertise and oversight for the provision of school health services and promotion of health education. Using clinical knowledge and judgment, the school nurse provides health care to students and staff, performs health screenings, and coordinates referrals to the medical home or private healthcare provider. The school nurse serves as a liaison between school personnel, family, community and healthcare providers to advocate for health care and a healthy school environment (National Association of School Nurses / American Nurses Association [NASN / ANA], 2005).

SPECIAL DIETARY NEEDS

An individual who does not have a disability, as defined in 7 CFR 15(b), but is unable to consume a particular food because of a medical or other special dietary condition is considered to have a special dietary need. The individual's special dietary need and the needed substitution(s) must be supported by a medical statement from a licensed medical authority or other appropriate health professional as designated by the State. A person with special dietary needs may have a food allergy or intolerance (for example, lactose intolerance) but does not have life-threatening (anaphylactic) reactions when exposed to food(s) to which he/she is allergic.

Food Allergies in Schools: Do You Need a 504 Plan for a Food Allergy?

From Victoria Groce, former About.com Guide

Updated October 21, 2008

About.com Health's Disease and Condition content is reviewed by our Medical Review Board

What is a 504 Plan?

A major provision of the Rehabilitation Act of 1973 (29 U.S.C. § 794) requires school districts to provide all students, regardless of disability, with a "free appropriate public education." This provision, found in section 504, applies to any condition - physical, mental, or emotional - that might interfere with a student's ability to receive an education in a public school classroom, subject to external review.

504 Plans, named for that section of the Act, are comprehensive plans created collaboratively by parents, nurses, and other interested parties to address the student's individual needs.

How Can a 504 Plan Help Students Manage Food Allergies in Schools?

Severe food allergies are one of the conditions that may fall under the Rehabilitation Act. Among the issues 504 Plans for students with severe food allergies may address are where life-saving anaphylaxis medications will be stored, where students will eat lunches and snacks, whether allergens will be permitted on the school campus, and if so, where, and how teachers, nurses, and other school personnel will be trained to recognize food allergy symptoms.

504 Plans may also provide a framework for parents to discuss self-care responsibilities with their children, and for parents to clearly discuss with school staff what their children can and cannot do for themselves with respect to keeping safe from allergens in a school setting.

Are All Students with Food Allergies Eligible For 504 Plans?

Likely not. In order to be considered eligible for a 504 Plan, a student must have a condition that "substantially limits one or more major life activities," which are then defined further within the law. In order to determine eligibility, students are evaluated by the school district prior to creating the 504 Plan (if students are denied 504 Plan protection, parents have the option to appeal the ruling).

The factors the school district considers in evaluating the student includes the severity of the condition and the student's ability to provide self-care. Thus, a kindergarten student with an

anaphylactic peanut allergy who cannot yet read would almost certainly be considered eligible under the terms of the law; a high school student of normal intelligence with a milk allergy whose major symptom is rhinitis likely would not.

Current Status

In addition to the Rehabilitation Act, several other laws protect students with food allergies. These include the 1990 Americans with Disabilities Act (ADA) and the Individuals with Disabilities Education Act. The ADA, in particular, may establish some measure of legal protection for students in private schools and day care centers (the Rehabilitation Act applies specifically to public schools).

Several states have also passed laws that allow students to carry injectable epinephrine at school and Good Samaritan laws that can shield from legal liability school personnel who administer epinephrine to anyone they believe in good faith to be having a severe allergic reaction. (You can learn more about these and other legal developments relevant to the schooling of allergic children through the Food Allergy and Anaphylaxis Network's Advocacy in Schools page.)

Public controversy about peanut bans at schools notwithstanding, legal protections for severe food allergies in schools have been consistently enforced. As the number of students with severe food allergies rises, more and more school districts are reviewing allergy policies, or creating new ones.

Fuss

Why go to the trouble of creating a 504 Plan when you could just sit down with your child's teacher and principal before the school year starts and come to an informal agreement? Well, the major difference between a 504 Plan and this sort of casual discussion with teachers and administrators at the beginning of each school year is that a 504 Plan is a legal document. If the plan is not enforced, parents have legal recourse to the United States Office of Civil Rights or to the local courts, depending on the jurisdiction. (As always, an attorney is the best source of answers for specific legal questions.)

If your school is reluctant to make changes that you feel are necessary for your child's safety, going through the outside evaluation process and getting a 504 Plan may be the best way to protect your child in the classroom. Even if your relationship with your school has been cordial, having a formal, legally enforceable plan may prevent your relationship with the school from becoming adversarial because expectations for all parties - parents, children, classmates, food services workers, nurses, and administration - should be clear after the 504 is completed.

*Note to Parents: Ultimately, 504 Plans are completely optional. Whether you believe your child will benefit from having one is a call that only you can make.

WEBSITES OF INTEREST

NFSMI INSIGHT – HANDBOOK FOR CHILDREN WITH SPECIAL FOOD & NUTRITION NEEDS
National Food Service Management Institute.
Web Site: www.nfsmi-web01.nfsmi.olemiss.edu/documentlibraryfiles/
Summary: Identifies the developmental disabilities and other health care needs to be served by school food service and provides intervention resources.

RESOURCES ON FOOD ALLERGIES, SPECIAL DIETS & SPECIAL NEEDS
Healthy School Meals Resource System on-line information center for USDA Child Nutrition Programs (CNP).
Web Site: www.healthymeals.nal.usda.gov

FOOD AND NUTRITION INFORMATION CENTER (FNIC).
FNIC is a leader in on-line global nutrition information located at the USDA's National Agricultural Library (NAL). The FNIC website contains over 2500 links to current and reliable nutrition information.
Web Site: www.fnic.nal.usda.gov

NATIONAL AGRICULTURE LIBRARY (NAL)
NAL houses one of the world's largest and most accessible agricultural information collections.
Web Site: www.nal.usda.gov

NATIONAL INFORMATION CENTER FOR CHILDREN AND YOUTH WITH DISABILITIES (NICHCY)
NICHCY is an information and referral center for children with disabilities and disability related issues which receives funding through the U.S. Department of Education. Information specialists provide information in English and Spanish regarding services about specific disabilities, special education and related services, education programs, family issues or disability organizations. NICHCY staff has prepared State Resource Sheets for each State which can be downloaded from its web site. The resource sheet for your State will help you locate government agencies, chapters of disability organizations, parent training and information projects. The resource sheet can also refer you to local sources of information and assistance.
Web Site: www.nichcy.org

COPIES OF FEDERAL LAWS:

- Section 504 of the Rehabilitation Act of 1973, 29 U>S>C> 794, implementing regulations at 34 CFR Part 104. **www.ed.gov/ocr/disability.html**

- Title II of the Americans with Disabilities Act of 1990, 42 U>S>C> 12134 et seq., implementing regulations at 28 CFR Part 35. **www.ed.gov/ocr/disability.html**

- Individuals with Disabilities Education Act, 20 U.S>C. 111 et seq.,implementing regulations at 34 CFR Part 300. **www.ed.gov/offices/OSERS/OSEP**

- Family Education Rights and Privacy Act (FERPA), **www.ed.gov/offices/OM/fpco**

American Academy of Allergy
Asthma, and Immunology
www.aaaai.org

Cleft Palate Foundation
www.cleftline.org

American Academy of Pediatrics
www.aap.org

Easter Seals
www.easterseals.com/site/pageserver

American Cancer Society
www.cancer.org

Epilepsy Foundation of America
www.epilepsyfoundation.org

American Diabetes Association
www.diabetes.org

Food Allergy & Anaphylaxis Network Inc.
www.foodallergy.org

American Heart Association
www.heart.org/HEARTORG/

Muscular Dystrophy Association of America
www.mdausa.org

Crohn's and Colitis Foundation of America, Inc
www.ccfa.org

United Cerebral Palsy Association
www.ucp.org/

Autism Society of America
www.autism-society.org

Spina Bifida Association of America
www.sbaa.org

Association for Retarded Citizens (The ARC)
www.thearc.org

National Cystic Fibrosis Foundation
www.cff.org

Arthritis Foundation
www.arthritis.org

USDA REFERENCES AND CFR CITATION

UNITED STATES DEPARTMENT OF AGRICULTURE
Food and Nutrition Service
3101 Park Center Drive
Alexandria, VA 22302

ACTION BY: Regional Directors
Special Nutrition Programs

SOURCE CITATION: Rehabilitation Act of 1973, Section 504;
7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b), 215.14, 220.8(f), 225.16(g)(4), and 226.20(h)

Meal Substitutions for Medical Or Other Special Dietary Reasons

Child Nutrition Program regulations require participating school food authorities, institutions and sponsors to offer to all participants breakfasts, lunches, suppers, supplements and milk which meet the meal patterns identified in the Program regulations. Departmental regulations further require substitutions to the standard meal patterns for participants who are considered handicapped under 7 CFR Part 15b and whose handicap restricts their diet; and permit substitutions for other participants who are not handicapped but are unable to consume regular Program meals because of medical or other special dietary needs. The provisions requiring substitutions for handicapped participants respond to the requirements of Section 504 of the Rehabilitation Act of 1973 and to the U.S. Department of Agriculture's implementing regulations, 7 CFR Part 15b, which provide that no otherwise qualified handicapped individuals shall, solely on the basis of handicap, be excluded from participation in, be denied benefit of, or subjected to discrimination under any program or activity receiving Federal financial assistance.

This Instruction outlines the policy for food substitutions and other modifications in the meal patterns necessary to meet the dietary requirements of Program participants with handicaps and with other special dietary needs. School food authorities, institutions and sponsors are required to offer Program meals to participants with handicaps whenever Program meals are offered to the general populations served by the Programs. School food authorities, institutions and sponsors should be aware that the

Individuals with Disabilities Education Act (IDEA), imposes requirements on States which may affect them, including the service of meals even when such service is not required by the Child Nutrition Programs.

For example, the individualized education program developed for a child under the IDEA may require a meal to be served outside of the regular meal schedule for Program meals or may require a breakfast to be served in a school food authority which does not participate in the School Breakfast Program. While the school food authority, institution or sponsor may not claim these meals as Program meals, it may use the same food service facilities or food service management company to provide these meals as it uses to provide Program meals, and Program funds may be used to pay for the costs associated with the IDEA-required meals. Inquiries regarding the IDEA's requirements should be directed to the U.S. Department of Education, the Agency responsible for the IDEA's administration and enforcement.

School food authorities, institutions and sponsors may also have responsibilities under the Americans with Disabilities Act (ADA). Inquiries regarding a school food authorities', institution's or sponsor's responsibilities under the ADA should be directed to the U.S. Department of Education, the agency responsible for the enforcement of the ADA's requirements in elementary and secondary education systems.

I HANDICAPPED PARTICIPANTS

"Handicapped person" is defined in 7 CFR 15b.3(i) as any person who has "a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment." (See Exhibit A, 7 CFR 15b.3.) "Major - life activities" are defined in 7 CFR 15b.3(k) as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working." School food authorities, institutions and sponsors participating in the Child Nutrition Programs are required to make substitutions or modifications to the meal patterns for those participants with handicaps who are unable to consume the meals offered to non-handicapped participants.

(I)

Determinations of whether or not a participant has a handicap which restricts his or her diet are to be made on an individual basis by a licensed physician. (Licensed physicians include Doctors of Osteopathy in many states.) The physician's medical statement of the participant's handicap must be based on the regulatory criteria for "handicapped person" defined in 7 CFR Part 15b.3(i) and contain a finding that the handicap restricts the participant's diet. In those cases in which the school food authority, institution or sponsor has consulted with the physician issuing the statement and is still unclear whether the medical statement meets the regulatory criteria, the school food authority, institution or sponsor may consult the State agency.

A participant whose handicap restricts his or her diet shall be provided substitutions in foods only when supported by a statement signed by a licensed physician. The medical statement shall identify:

A. The participant's handicap and an explanation of why the handicap restricts the participant's diet;
B. The major life activity affected by the handicap; and
C. The food or foods to be omitted from the participant's diet, and the food or choice of foods that must be substituted.

If the handicap would require caloric modifications or the substitution of a liquid nutritive formula, for example, this information must be included in the statement. If the handicapped participant requires only textural modification(s) to the regular Program meal, as opposed to a meal pattern modification, the medical statement is recommended, but not required. In such cases, the purpose of the statement is to assist the school food authority, institution or sponsor in providing the appropriate textural modification(s). Unless otherwise specified by the physician, the meals modified for texture will consist only of food items and quantities specified in the regular menus.

The State agency should make 7 CFR 15b.3 (Exhibit A) available to school food authorities, institutions and sponsors. The school food authority, institution or sponsor should also provide parents or guardians with 7 CFR Part 15b.3, so that their physicians may correctly assess whether an individual's handicap meets the regulatory criteria. School food authorities, institutions and sponsors should use the services of a Registered Dietitian to assist in implementing the medical statement, as appropriate.

(I)

Generally, participants with food allergies or intolerances, or obese participants are not "handicapped persons", as defined in 7 CFR 15b.3(i), and school food authorities, institutions and sponsors are not required to make substitutions for them. However, when in the physician's assessment food allergies may result in severe, life-threatening reactions (anaphylactic reactions) or the obesity is severe enough to substantially limit a major life activity, the participant then meets the definition of "handicapped person", and the food service personnel must make the substitutions prescribed by the physician.

(II)

PARTICIPANTS WITH OTHER SPECIAL DIETARY NEEDS

School food authorities, institutions or sponsors may, at their discretion, make substitutions for individual participants who are not "handicapped persons", as defined in 7 CFR Part 15b.3(i), but who are unable to consume a food item because of medical or other special dietary needs. Such substitutions may only be made on a case-by-case basis when supported by a statement signed by a recognized medical authority. In these cases, recognized medical authorities may include physicians, physician assistants, nurse practitioners or other professionals specified by the State agency.

For these non-handicapped participants, the supporting statement shall include:

A. An identification of the medical or other special dietary need which restricts the participant's diet; and
B The food or foods to be omitted from the participant's diet, and the food, or choice of foods, that may be substituted.

School food authorities, institutions and sponsors are not required to make substitutions for participants whose conditions do not meet the definition of "handicapped person" set forth in 7 CFR 15b.3 (i). For example, individuals who are overweight or have elevated blood cholesterol generally do not meet the definition of handicapped person, and thus school food authorities, institutions, and sponsors are not required to make meal substitutions for them. In fact, in most cases, the special dietary needs of non-handicapped participants may be managed within the normal Program meal service when a well-planned variety of nutritious foods is available to children, and/or "offer versus serve" is available and implemented.

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REV. 2

(II)

(III) REIMBURSEMENT AND AVAILABILITY OF SUBSTITUTIONS

Reimbursement for meals served with an authorized substitute food to handicapped participants or to participants with other special dietary needs shall be claimed at the same reimbursement rate as meals which meet the meal pattern. Furthermore, there shall not be a supplementary charge for the substituted food item(s) to either a handicapped participant or to a participant with other special dietary needs. 7 CFR 15b.26(d)(1) specifies that, in providing food services, recipients of Federal financial assistance "may not discriminate on the basis of handicap" and "shall serve special meals, at no extra charge, to students whose handicap restricts their diet." While any additional costs for substituted foods are considered allowable Program costs, no additional Child Nutrition Program reimbursement is available. Sources of supplemental funding may include special education funds (if the substituted food is specified in the child's individualized education program); the general account of the school food authority, institution or sponsor; or, for school food authorities, the nonprofit school food service account.

(IV) ACCESSIBILITY

7 CFR 15b.26(d)(2) provides: "Where existing food service facilities are not completely accessible and usable, recipients may provide aides or use other equally effective methods to serve food to handicapped persons." The school food authority, institution or sponsor is responsible for the accessibility of food service sites and for ensuring the provision of aides, where needed. As with additional costs for substituted foods, any additional costs for adaptive feeding equipment or for aides are considered allowable costs. However, no additional Child Nutrition Program reimbursement is available. Sources of supplemental funding may include special education funds (if specified in the child's individualized education program); the general account of the school food authority, institution or sponsor; or, for school food authorities, the nonprofit school food service account.

(IV)
7 CFR 15b.26(d)(2) further provides that recipients provide all food services in the most integrated setting appropriate to the needs of the handicapped persons as required by 7 CFR 15b.23(b).

That section requires Program recipients to ensure that handicapped persons participate with non-handicapped persons to the maximum extent appropriate to the needs of the handicapped person in question.

V COOPERATION

When implementing the guidelines of this Instruction, food service personnel should work closely with the parent(s) or responsible family member(s) and with all other school, child care, medical and community personnel who are responsible for the health, well-being and education of participants with handicaps or with other special dietary needs to ensure that reasonable accommodations are made to allow such individuals', participation in the meal service. This cooperation is particularly important when accommodating children or elderly adults whose handicapping conditions require significant modifications or personal assistance.

Cynthia Long
Director
Child Nutrition Division

§15b.3 Definitions As used in this part, the term or phrase:
(a) “The Act” means the Rehabilitation Act of 1973, Public Law 93-112, 87 Stat. 390 (1973), as amended by the Rehabilitation Act Amendments of 1974, Public Law 93-651, 89 Stat. 2 (1974) and Public Law 93-516, 88 Stat. 1617 (1974) and the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, Public Law 95-602, 92 Stat. 2955 (1978). The Act appears at 29 U.S.C. 701-794.
(b) "Section 504” means section 504 of the Act, 29 U.S.C. 794.
(c) "Education of the Handicapped Act” means the Education of the Handicapped Act, Public Law 92-230, Title VI, 84 Stat. 175 (1970), as amended by the Education of the Handicapped Amendments of 1974, Public Law 93-380, Title VI, 88 Stat. 576, (1974), the Education for All Handicapped Children Act of 1975, Public Law 94-142, 89 Stat. 773 (1975), and the Education of the Handicapped Amendments of 1977, Public Law 95-49, 91 Stat. 230 (1977). The Education of the Handicapped Act appears at 20 U.S.C. 1401- 1461.
(d) "Department” means the Department of Agriculture and includes each of its operating agencies and other organizational units.
(e) "Secretary” means the Secretary of Agriculture or any officer or employee of the Department to whom the Secretary has delegated or may delegate the authority to act under the regulations of this part.
(f) "Recipient" means any State or its political subdivision, any instrumentality of a State or its political subdivision, any public or private agency, institution, organization, or other entity, or any person to which Federal financial assistance is extended directly or through another recipient, including any successor, assignee, or transferee of a recipient, but excluding the ultimate beneficiary of the assistance.
(g) “Federal financial assistance" or “assistance” means any grant, contract (other than a procurement contract or a contract of insurance or guaranty), cooperative agreement, formula allocation, loan, or any other arrangement by which the Department provides or otherwise makes available assistance in the form of:
(1) Funds;
(2) Services of Federal personnel;
(3) Real and personal Federal property or any interest in Federal property, including:
(i) A sale, transfer, lease or use (on other than a casual or transient basis) of Federal property for less than fair market value, for reduced consideration or in recognition of the public nature of the recipient’s program or activity; and
(ii) Proceeds from a subsequent sale, transfer or lease of Federal property if the Federal share of its fair market value is not returned to the Federal government.
(4) Any other thing of value.
(h) “Facility” means all or any portion of buildings, structures, equipment, roads, walks, parking lots, or other real or personal property or interest in such property.
(i) “Handicapped person” means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.
(j) "Physical or mental impairment” means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term “Physical or mental impairment” includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis, cancer, heart disease; diabetes; mental retardation; emotional illness; and drug addiction and alcoholism.
(k) “Major life activities” means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.
(l)”Has a record of such an impairment” means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.
(m) “Is regarded as having an impairment” means, (1) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (2) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others towards such impairments, or (3) has none of the impairments defined in paragraph (j) of this section but is treated by a recipient as having such an impairment.
(n) “Qualified handicapped person” (used synonymously with “otherwise qualified handicapped individual”) means:
(1) With respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question, but the term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others;
(2) With respect to public preschool, elementary, secondary or adult educational services, a handicapped person, (i) of an age during which non-handicapped persons are provided such services, (ii) of an age during which it is mandatory under State law to provide such services to handicapped persons, or (iii) to whom a State is required to provide a free appropriate public education under section 612 of the Education of the Handicapped Act; and
(3) With respect to postsecondary and vocational education services, a handicapped person who meets all academic and technical standards requisite to admission or participation in the recipient’s education program or activity;
(4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.
(o) “Handicap” means any condition or characteristic that renders a person a handicapped person as defined in paragraph (i) of this section.
(p) for purposes of §15b.18(d), “Historic preservation programs” means programs receiving federal financial assistance that has preservation of historic properties as a primary purpose.
(q) For purposes of §15b.18(e), “Historic properties” means those buildings or facilities that are eligible for listing in the National Register of Historic Places, or such properties designated as historic under a statute of the appropriate State or local government body.
(r) For purposes of §15b.18(d), “Substantial impairment” means a significant loss of the integrity of finished materials, design quality or special character which loss results from a permanent alteration.

In order to provide the best possible service to our students and school community it is recommended to use a coordinated approach.

WHAT IS COORDINATED SCHOOL HEALTH?

The Centers for Disease Control and Prevention (CDC) encourages using a coordinated approach to creating and supporting a healthy school environment that will promote the health and success of the child. The key to Coordinated School Health (CSH) is a well functioning School Health Advisory Council that links the components of CSH as well as a Local Wellness Policy created through a district-wide effort amongst various stakeholders. The eight components of Coordinated School Health include: Physical Education, Health Education, Counseling & Psychological Services, Health Services, Family and Community Involvement, Health Promotion for Staff, Healthy School Environment, and Nutrition Services.

Please visit our website: http://www.healthologyaz.com/

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