



## Medical Statement for Special Diet Accommodations

The United States Department of Agriculture guidelines require school food authorities participating in the National School Lunch Program to make reasonable accommodations available to students with disabilities, on a case-by-case basis, when the need is supported by a written medical statement.

The Americans with Disabilities (ADA) Amendments Act of 2008 (Public Law 110-325, 42 U.S.C. 12101) updated the definition of a disability to include “anyone with a physical or mental impairment that substantially limits one or more major life activities of that individual”, including major bodily functions as a major life activity.

According to the USDA, school food authorities are not required to accommodate special diet requests based on dietary preferences that are not considered medical conditions or disabilities, including personal lifestyle choices (such as vegan, vegetarianism, organic) or religious choices.

This form must be completed by a state licensed physician, physician assistant or nurse practitioner. Updates to this form are required only when a participant’s needs change.

### Participant Information

Participant’s Name: \_\_\_\_\_ Today’s Date: \_\_\_\_\_

Name of School Attended/Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

### Required Information: Dietary Accommodation

- State the allergen or food to be avoided:  
\_\_\_\_\_
- Brief explanation of how exposure to this food affects the participant:  
 Breathing     Operation of major bodily function (immune system, bowel, digestive, etc.)  
 Other, specify: \_\_\_\_\_
- List specific foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

### Additional Information

Texture Modification (check or describe, if any):     Pureed     Ground/Mechanical Soft     Bite-Sized Pieces  
Other: \_\_\_\_\_

Other Dietary Modification or Additional Instructions (describe, if any):  
\_\_\_\_\_  
\_\_\_\_\_

## Medical Professional's Signature

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain a copy of this document. In the state of Ohio, a Licensed (LD) Registered Dietitian/ Nutritionist (RDN)) can assist with the completion of this form, however, a licensed physician, physician assistant, or advanced practice registered nurse must still co-sign.

Prescribing Authority Credentials (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature (only required if signed by RDN/LD): \_\_\_\_\_ Date: \_\_\_\_\_

Clinic/Hospital: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Voluntary Authorization Note to Parent(s)/Guardian(s)/Participant

You may authorize the director of the school/center/site to clarify this Special Diet Statement with the physician by signing the following Voluntary Authorization section: In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize \_\_\_\_\_ (physician/medical authority name) to release such protected health information as is necessary for the specific purpose of Special Diet information to \_\_\_\_\_ (program name) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. Optional: My permission to release this information will expire on \_\_\_\_\_ (date). This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR Participant's Signature (Adult Day Care): \_\_\_\_\_

## Questions?

If you have any questions regarding this form and/or special dietary accommodations under the National School Lunch Program at Dublin City Schools, please reach out to the food service District Dietitian: [dietitian\\_cook@dublinschools.net](mailto:dietitian_cook@dublinschools.net)

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov).

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