

INDEPENDENT SCHOOL DISTRICT 196  
Rosemount-Apple Valley-Eagan Public Schools  
*Educating, developing, and inspiring our students for lifelong success.*

Series Number **710.2.4P** \_\_\_\_\_ Adopted **November 2018** \_\_\_\_\_ Revised **July 2024** \_\_\_\_\_

Title **Special Diet Statement** \_\_\_\_\_

**Instructions:** Submit this completed special diet statement to the School Nurse. This form is in three parts. Part one must be completed by the parent, guardian or adult student. Part two must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. Part 3 provides legal notices for review. Updates to this form are required only when a student’s needs change.

### Part 1: Student Information – Completed by Parent/Guardian

Student’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last/First/Middle Initial Month/Day/Year

Name of School/Program: \_\_\_\_\_ Today’s Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Does your student plan on eating school meals?  Yes  No

If yes:

- Both Breakfast & Lunch  Only Lunch  Only Breakfast
- Select days/meals communicated to Nutrition Services Site Manager

### Voluntary Authorization

Note to Parent(s)/Guardian(s)/Adult Student: You may authorize District 196 to clarify this Special Diet Statement with the student’s health care professional by signing the following Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Family Educational Rights and Privacy Act and corresponding state law I hereby authorize the below identified physician/health care professional to release such protected health information as is necessary for the specific purpose of providing dietary information to District 196 and I consent to allow the physician/health care professional to freely exchange the information listed on this form and in their records with District 196 as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet. I understand that permission to release this information may be rescinded at any time, except my rescission will not affect information that has already been released. This information is to be released for the specific purpose of my request for a Special Diet. The undersigned certifies that he/she is the parent, guardian, adult student or authorized representative of the student listed on this document and has the legal authority to sign on behalf of that student.

Parent/Guardian/Adult Student: \_\_\_\_\_ Date: \_\_\_\_\_

## Part 2: Dietary Accommodation – Completed by Health Care Professional (Licensed physician, physician assistant, or an advanced practice registered nurse)

1. Identify the allergen(s) to be avoided:

Milk  Eggs  Fish  Crustacean Shellfish  Peanuts  Tree Nuts  Wheat  Soy  Sesame

Other: \_\_\_\_\_

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

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3. List specific foods to be omitted and substituted, if appropriate. Attach additional instructions as needed.

*Note: the School District is not required to provide the exact substitution requested, but will offer a reasonable substitution that effectively accommodates the student's disability.*

Foods to be Omitted	Foods to be Substituted

4. Can the allergen be consumed in baked items?

Yes: state the allergen(s) \_\_\_\_\_  No  N/A

### Additional Information (complete if applicable)

Texture Modification:  Pureed  Ground  Bite-Sized Pieces  Other: \_\_\_\_\_

Tube Feeding: Formula Name: \_\_\_\_\_

Administering Instructions: \_\_\_\_\_

Oral Feeding:  No  Yes if yes, specify foods: \_\_\_\_\_

Other Dietary Modifications or Additions Instructions (describe): \_\_\_\_\_

### Signature

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

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Prescribing Credentials: \_\_\_\_\_ Clinic/Hospital: \_\_\_\_\_

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

X \_\_\_\_\_

Health Care Professional's Signature

## Part 3: Notices

### Purpose and Use

Institutions or organizations such as District 196 who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet: School Nutrition Program – 7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4). According to the ADA Amendments Act, most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.

District 196 is not required to accommodate special dietary requests that do not constitute a disability, including requests related to religious or moral convictions or personal preference. If these requests are accommodated, District 196 must ensure that all USDA meal pattern and nutrient requirements are met.

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. Updates to this form are required only when a student's needs change.

Information provided on this form will be used to determine if your student is eligible for reasonable substitutions to meals based on a disability. Except as otherwise permitted by law or required by a subpoena or court order, information supplied on this form will only be shared with District 196 staff with a legitimate need to know such information (such as the school nurse and Food and Nutrition staff involved in assessing and accommodating meal substitution requests). You are not obligated to provide the information on this form, but if you do not do so, the school district may not be able to offer a reasonable meal substitution to your student.

### Non-Discrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, District 196 is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint> from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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: (833) 256-1665 or (202) 690-7442; or
- (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov)

District 196 is an equal opportunity provider.