

Special Dietary Needs and Accommodations

This form may be (1) used by a licensed medical provider with prescriptive authority to provide a medical statement for a student's medical disability or a special dietary need that warrants a meal accommodation or (2) used to assist a licensed medical provider with prescriptive authority in creating the medical statement necessary for a meal accommodation. If this form is used as a medical statement, the form must be completed by the medical provider and signed by both the parent or guardian and the medical authority.

Date: _____

Part I: General Information : To be completed by Parent/Guardian

Student Name (Last): _____ (First): _____

Date of Birth: ___/___/___

School Attending: _____ Grade: _____

Student ID#: _____

Which meals will the child eat at school? (please circle)

Breakfast / Lunch / After School Snack (if applicable)

School Nurse/ Nurse Consultant: _____

Contact Information: _____

Parent/Guardian: _____ Phone Number: _____

Email: _____

I give Health Services/ Food Services permission to speak with the named Physician or Authorized Medical Provider to discuss the dietary needs described on this form.

Parent/Guardian Signature _____

Date _____

Part II: To be completed by a Medical Provider with Prescriptive Authority:

Does the student have a medical disability which affects one of the major life functions which necessitates a meal accommodation?

Yes

No

Does the student have a special dietary need that will be helped by a meal accommodation?

Yes

No

How does this medical disability or special dietary need impact the student's diet?

Part III: To be completed by a Medical Provider with Prescriptive Authority:

What meal accommodation(s) are appropriate to address the student's medical disability or

special dietary needs? Please check the box before applicable meal accommodations and provide a detailed explanation for each checked accommodation in the box beside the description.

Food items or ingredients not to be served

Suggested substitutions for food items not served

Specific description of texture modifications for specific food types or items

Other

Name of Medical Provider (please print): _____

Signature: _____

Date: _____

Phone: _____

Fax: _____

Mailing Address: _____

Send completed forms to the school nurse/nurse consultant. Any change of treatment must be requested in writing by the provider or by a parent. If received from a parent, communication to a medical provider may be warranted. To ensure that the accommodation can be provided on the first day of school, submit this form no later than one month prior to the first day of school.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution 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/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, 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. This institution is an equal opportunity provider.