MICHIGAN Department of Education

Special Diet Request Form

This form needs to be completed when accommodations for a child are required in the Child Nutrition Program* meals due to medical reasons, disabilities, or severe allergies. The form must be filled out by a state licensed medical provider and parent/guardian, signed, and returned to _____

Participant Information: (completed by parent/guardian)
Participant's full name: _____Date: _____
Date of birth: _____
Name of school/center/site attends: _____
Parent/guardian name: _____
Phone number: (Cell)_____Other: _____
Updates to this form are required only if the child's needs have changed.

Required Information: Dietary Accommodation (completed by medical provider)

1. List food(s) to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

2. Briefly explain how exposure to the food(s) affects the participant.

Additional Information
Texture modification (circle): Pureed Minced & Moist Soft & Bite Sized Easy to Chew
Tube feeding:_____Formula name:_____
Administering instructions:_____
Other dietary modification or additional instructions:_____

Required Signature
Form must be signed by a state licensed Physician (MD or DO), Physician Assistant (PA), an Advanced Practiced Provider (Nurse Practitioner or NP, Advanced Practice Registered Nurse or APRN), or a Registered Dietitian (RD or RDN).
Prescribing authority name & Credentials (print):_____
Signature:_____Date: _____
Clinic/Hospital:_____
Phone number:_____Fax number: _____

*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)

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may allow the director of the school/center/site to talk with the medical person about this Special Diet Request Form by signing the Voluntary Authorization section:

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

Parent/Guardian: _____Date: _____

Or Participant's Signature (Adult Day Care ONLY): _____

USDA Non-Discrimination Statement

In accordance with federal civil rights law and the 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: USDA Program Discrimination Complaint Form, from any USDA office, by calling (866) 632-992, or 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; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: Program.Intake@usda.gov

This institution is an equal opportunity provider.