# Aramark
## Child Nutrition Programs Special Diet Form

**Guidelines for Students with Special Diets**

If your child has been identified by a physician to require a specialty diet, changes can be made to your child's meals at no extra charge.

Children will be considered eligible based on the following:

- ☐ Rehabilitation Act of 1973 and the Americans with Disabilities Act
- ☐ Individuals with Disabilities Education Act

U.S. Department of Agriculture (USDA) regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. School food authorities must provide modifications for children with disabilities on a case-by-case basis when requests are supported by a written statement from a state licensed medical practitioner. The licensed medical practitioner's statement must identify:

- an explanation of how the child's physical or mental impairment restricts the child's diet;
- the food(s) to be avoided; and
- the food or choice of foods that must be substituted.

**Student Information**

First Name: _____ Last Name: _____ Date: _____

Student ID #: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian Name: _____ Email: _____

**Medical Information**

This school/facility participates in a federally funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable meal accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form.

If you have any questions, please contact _____(name) at _____ (phone).

**THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN ONLY.**

Does the student have an identified disability, food allergy, or food intolerance requiring a special diet?

- ☐ **Severe Allergy:** Student has a food allergy that is severe or causes an anaphylactic reaction.
- ☐ **Mild Allergy:** Student has a food allergy that is less severe or does not cause an anaphylactic reaction.
- ☐ **Food Intolerance:** Student has a food intolerance that requires a modified diet.
- ☐ **Disability:** Student has a disability that requires a modified diet.
- ☐ Other: _____

| Please complete all sections below that are applicable to the child | | |
|---|---|---|
| Allergies, Intolerances & Celiac Disease | What food(s)/type(s) of food should be omitted? Please be specific. | |
| | List of foods to be substituted. (Avoid brand names, if possible.) | |
| Diabetes Mellitus | Please describe any modifications necessary to accommodate the child's needs. | |
| Texture Modifications | The child requires that all foods be:<br>☐ Pureed<br>☐ Diced/Finely Ground<br>☐ Chopped/cut into bite sized pieces<br>☐ Other: _____ | Liquids should be:<br>☐ Pudding Thick<br>☐ Honey Thick<br>☐ Nectar Thick<br>☐ Thin/Normal consistency |
| Other | What food(s)/type(s) of food should be omitted? Please be specific. | |
| | List of foods to be substituted. (Avoid brand names, if possible.) | |

Additional Comments:

| **Signature Required:**<br>Please check the appropriate title: | ☐ Physician<br>☐ Physician Assistant | ☐ Nurse Practitioner<br>☐ Dentist | ☐ Podiatrist<br>☐ Optometrist |
|---|---|---|---|

I certify that the above-named student requires food substitutes as a described above due to their disability, food allergy, or food intolerance.

Medical Practitioner's Name: _____

Medical Practitioner's Signature: _____

Title: _____

Phone Number: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (please print): _____ Phone: _____

This institution is an equal opportunity employer.
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