## **Special Diet Statement**

Institutions or organizations 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.

Sponsors are 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, sponsors 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 participant's needs change.

Note to Districts/Schools: Parents/Guardians may provide a written request for lactose-reduced milk without a physician's signature.

physician's signature.		
Submit this completed special diet statement to:		
Participant Information		
Participant's Name:	Today's Date:	
Last/First/Midd	lle Initial	
Name of School/Center/Site Attended:	Date of Birth:	
Parent/Guardian Name:		
Home Phone Number:	Work Phone Number:	
Required Information: Dietary Accommo	odation	
1. State the allergen or food to be avoided:		
2. Brief explanation of how exposure to this food a	affects the participant:	
List specific foods to be omitted and substituted	d. Attach a sheet with additional instructions as needed.	
Foods to be Omitted	Foods to be Substituted	
Additional Information		
Texture Modification: Pureed Ground	Bite-Sized Pieces Other:	
Tube Feeding Formula Name:		
Administering Instructions:		
	;	
Other Dietary Modification Or Additional Instruc		

## **Signature**

sign and return a copy of this document.	
Prescribing Authority Credentials (print):	Date:
Signature:	Clinic/Hospital:
Phone Number:	Fax Number:
Voluntary Authorization	
Note to Parent(s)/Guardian(s)/Participant: You n Diet Statement with the physician by signing the	nay authorize the director of the school/center/site to clarify this Special following Voluntary Authorization section:
·	Insurance Portability and Accountability Act (HIPAA) of 1996 and the by authorize
(physician/medical authority name) to release	such protected health information as is necessary for the specific
	(program name) and I consent to allow
	nge the information listed on this form and in their records
	I understand that I may refuse to sign this authorization without
- , , , ,	cial diet for me. I understand that permission to release this
	pt when the information has already been released. Optional: My re on(date). This information is to be released
	tion. The undersigned certifies that he/she is the parent, guardian, or
, , , , , , , , , , , , , , , , , , ,	ted on this document and has the legal authority to sign on behalf of
that participant.	ica on this document and has the legal datherity to sign on behalf of
Parent/Guardian:	Date:
OR Participant's Signature (Adult Day Care):	

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must

## **Non-Discrimination**

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: <a href="https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf">https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf</a>, 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:

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

This institution is an equal opportunity provider.