Dear Licensed Medical Provider,

In recent years, we have seen increasing emphasis on the importance of ensuring that children with disabilities have the same opportunities as other children to receive an education and education-related benefits, such as school meals. Subsequently, Congress has passed several comprehensive Acts or laws, which broaden and extend civil rights protections for Americans with disabilities. One result of these laws is an increase in the number of children with disabilities who are being educated in regular school programs. In some cases, the disability may prevent the child from eating meals prepared for the general school population.

USDA regulations (7 CFR 15b) require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability that restricts his or her diet must receive food substitutions when a statement signed by a licensed medical physician, physician assistant, or advanced practice registered nurse (e.g. certified nurse practitioner) supports that need (USDA 7 CFR 210.10). The medical provider's statement must identify:

- The allergen(s) or food(s) to be avoided
- Explanation of how exposure to the allergen(s)/food(s) affects the child
- The food(s) to be omitted from the child's diet and the food or choice of foods that must be substituted

Enclosed is a blank special diet statement for you to complete for a student currently enrolled in one of our schools. The form must be completed in its entirety and signed by you. Please contact me at 507-645-3432 if you have any questions.

Respectfully,

Stephany Stromme, RDLD
Director of Child Nutrition
Northfield Public Schools
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.

Participant Information

Participant’s Name: ________________________________________________ Today’s Date: ________________

Last/First/Middle Initial

Name of School/Center/Site Attended: ________________________________ Date of Birth: ________________

Parent/Guardian Name: _______________________________________________________________________

Home Phone Number: ___________________________ Work Phone Number: ___________________________

Required Information: Dietary Accommodation

1. State the allergen or food to be avoided:

________________________________________________________________________________________

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

________________________________________________________________________________________

3. List specific foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

<table>
<thead>
<tr>
<th>Foods to be Omitted</th>
<th>Foods to be Substituted</th>
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<tbody>
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<td></td>
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Additional Information

☐ Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other: ________________________________

☐ Tube Feeding Formula Name: ________________________________

Administering Instructions: _____________________________________________________________________

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____________________________________________________________________

☐ Other Dietary Modification Or Additional Instructions (describe): _____________________________________________________________________
Signature

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain 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 may authorize the director of the school/center/site to clarify this Special Diet Statement with the physician by signing the following 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): ___________________________________________