Minnesota Department of Education

Special Diet Statement to Request Dietary Accommodations

1. Name of Participant: _____ 2. Age or Date of Birth: _____

3. Name of Parent or Guardian: _____ 4. Phone Number: _____

5. Sponsor Name: _____

6. Site Name: _____

7. Site Phone Number: _____

8. Check one:

☐ Participant **has a disability** or a medical condition and *requires* a special meal or dietary accommodation. An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the American with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits or affects one or more major life activities (i.e., eating, seeing, hearing, etc.) and/or major bodily functions (i.e., digestion, bowel, bladder, immune system, respiratory, endocrine, etc.). A sponsor who participates in any federal nutrition program **must** comply with requests for special meals, menu modifications and any adaptive equipment if the participant has a disability that affects their diet. **A licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign this form.**

☐ Participant **does not have a disability**, but is requesting a special meal or dietary accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. A sponsor who participates in any federal nutrition program is encouraged to accommodate reasonable requests for a participant without a disability but is not required to do so. **A licensed physician, physician assistant, certified nurse practitioner, registered dietitian, licensed nutritionist or chiropractor must sign this form.**

☐ Participant does not have a disability, but is requesting that they be served a **fluid milk substitute** that meets the nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. A sponsor who participates in any federal nutrition program is encouraged to accommodate a request for a fluid milk substitute but is not required to do so. **A licensed physician, certified nurse practitioner, registered dietitian, licensed nutritionist, chiropractor, parent or guardian must sign this form.**

9. State the disability or medical condition requiring a special meal or dietary accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity or bodily function that is affected by the disability: (refer to descriptions of major life activities or bodily functions on the instructions page).

11. State the diet prescription and/or dietary accommodation: (please describe in detail to ensure proper implementation—use extra pages as needed).

12. Foods to be omitted and recommended substitutions: (list specific foods to be omitted and specific foods to be substituted. (You may attach a sheet with additional information as needed).

Foods to be Omitted	Foods to be Substituted

13. Other Dietary Modifications OR Additional Instructions:

14. Texture Modifications: ☐ Bite Size Pieces ☐ Ground ☐ Pureed ☐ Other: _____

15. Tube Feeding: Formula Name: _____

Administering Instructions: _____

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

16. Adaptive Equipment: (if needed) _____

17. Signature of Preparer*****: _____

18. Printed Name: _____

19. Phone Number: _____ 20. Date: _____

21. Signature of Medical Authority******: _____

22. Printed Name: _____

23. Phone Number: _____ 24. Date: _____

**Signature of Preparer:* name of individual who completed the form.

***Signature of Medical Authority:* A signature from a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner is required for a participant with a disability. For a participant without a disability, a licensed physician, physician assistant, certified nurse practitioner, registered dietitian, licensed nutritionist or chiropractor must sign this form. A signature from a parent or legal guardian is acceptable when a request is made for a fluid milk substitution for a participant with special medical or dietary needs other than a disability.

The information on this form should be updated as needed to reflect the current medical and/or nutritional needs of the participant.

Request for Special Meals and/or Accommodations Instructions

1. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
2. **Age or Date of Birth:** Print the age or date of birth of the participant. For infants, please use date of birth.
3. **Name of Parent or Guardian:** Print the name of the person who is requesting a special diet or dietary modification on behalf of the participant.
4. **Phone Number:** Print the telephone number of parent or guardian.
5. **Sponsor Name:** Print the name of the sponsor that is providing the form to the parent.
6. **Site Name:** Print the name of the site where the meal will be served (e.g., school site, child care center, community center. etc.)
7. **Site Phone Number:** Print the phone number of the site where the meal will be served.
8. **Check one:** Check (√) a box to indicate whether participant has a disability, does not have a disability or does not have a disability and is requesting a fluid milk substitute.
9. **State the disability or medical condition requiring a special meal or dietary accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, severe allergy to peanuts, celiac, etc.)
10. **If participant has a disability, provide a brief description of participant's major life activity or bodily function that is affected by the disability:** An individual with a disability is described under Section 504 of the Rehabilitation Act (1973) and the American with Disabilities Act (ADA) as a person who has a physical or mental impairment that substantially limits or affects one or more major life activities (i.e., eating, seeing, hearing, etc.) and/or major bodily functions (i.e., digestion, bowel, bladder, immune system, respiratory, endocrine, etc.).
11. **State the diet prescription and/or dietary accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician for a participant with a disability, or describe a diet modification requested for a non-disabling condition. Examples for a participant with a disability include: "Gluten free diet." "Eliminate peanuts and all foods/beverages containing peanut components (patient requires Epi-pen)." Examples for a participant with a non-disabling condition: "Eliminate strawberries OR orange juice." "Participant cannot consume any solid foods; therefore, all foods must be either in liquid or pureed form."
12. A. **Foods to be Omitted:** List specific foods that must be omitted. For example: "Exclude fluid cow's milk."
    B. **Foods to be Substituted**: List specific foods to include in the diet. For example: "Provide an approved fluid milk substitute (soy based)."
13. **Other Dietary Modifications OR Additional Instructions:** Provide further instructions.
14. **Texture Modifications:** Check (√) a box to indicate the type of texture of food that is required. If the participant does not need any texture modifications, do not check any boxes.
15. **Tube Feeding:** Provide further instructions.
16. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.
17. **Signature of Preparer:** Signature of person completing form.
18. **Printed Name:** Print name of person completing form.
19. **Phone Number:** Phone number of person completing form.
20. **Date:** Date preparer signed form.
21. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation. *Note:* A signature from a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner is required for a participant with a disability.
22. **Printed Name:** Print name of medical authority.
23. **Phone Number:** Phone number of medical authority.
24. **Date:** Date medical authority signed form.

Voluntary Authorization

A parent/guardian/participant may choose to complete this section giving permission to the licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner to discuss and clarify a diet order with a director of a school, center or site.

Note to Parent(s)/Guardian(s)/Participant: As stipulated in FNS Instruction 783, Rev. 2, Section V Cooperation: "When implementing the guidelines of this instruction, food service personnel should work closely with the parent(s)/guardian(s)/participant or responsible family member(s) and with all other medical and community personnel who are responsible for the health, well-being and education of a participant with a disability that affects the diet to ensure that reasonable accommodations are made to allow the individual's participation in the meal service.

This voluntary authorization encourages such cooperation by allowing the following:

- After review of this Special Diet Statement, the school, center or site may need more information or clarification from the physician before it can provide the special diet. By signing this authorization you are permitting the school, center or site to discuss or clarify the diet order with the physician.
- Before any changes agreed to between the director of the school, center or site and physician take place, the parent(s)/guardian(s)/participant need to be informed.
- The changes agreed to will then be incorporated into an amended Special Diet Statement.
- If more information is needed but this authorization statement has not been signed, implementation of the special diet may be delayed.
- If authorization is signed, make a copy of this document before submitting to the school, center or site.

This authorizes the licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner to discuss or clarify the diet order prescribed for

_____ (participant's name) with the director at

_____ (name of school/center/site). This authorization will remain in effect until the diagnosis has changed or a new diet order is prescribed.

This authorization may be revoked at any time by submitting a request in writing to the licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner who originally signed the Special Diet Statement.

I understand that specific information disclosed pursuant to this authorization may be subject to re-disclosure by the school/center/site director and will no longer be protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

Parent/Guardian Signature:_____ Date:_____
OR Participant's Signature (Adult Day Care)