SPECIAL DIET STATEMENT
For a Participant *With* a Disability

This Special Diet Statement is ONLY for a participant *with* a disability that affects the diet. This form must be:

- Thoroughly completed and signed by a licensed physician.
- Submitted to the school/center/site before any meal modifications will be made in the United States Department of Agriculture Child Nutrition Programs.
- Updated whenever the participant's diagnosis or special diet changes.

PART 1: PARTICIPANT INFORMATION
PARENT OR GUARDIAN MUST COMPLETE. PLEASE PRINT.

Participant's Name: Last / First / Middle Initial			Today's Date:
Name of School/Center/Site Attended:			Date of Birth:
Parent/Guardian Name:	Home Phone Number:	Work Phone Number:	
Parent /Guardian Address:	City:	State:	Zip Code:

Meals or snacks to be eaten at school/center/site: (circle all that apply)

School:	**Center / Child Care / Adult Care Center:**	**Site–Summer Food Service Program:**
Breakfast Lunch	Breakfast Lunch Supper	Breakfast Lunch Supper Snack
Afterschool Care Program (snack)	am / pm / eve Snack Afterschool Snack	

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

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 Voluntary Authorization section at the end of this form.

PART 2: PARTICIPANT STATUS
LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT.

Participant has a disability and requires a special diet or food 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 one or more major life activities.

Refer to the document titled *Special Diet Statement Guidance* for definitions of "disability" and "major life activities" which is included with this form.

1. Identify the participant's disability:_____ **and/or**

   Identify food allergy that is life-threatening / anaphylactic (considered a disability):_____

2. Identify the "major life activities" affected by the disability:_____

3. Describe how the disability restricts the participant's diet: _____

_____

PART 3: DIETARY ACCOMMODATION
FOODS TO BE OMITTED AND FOODS TO BE SUBSTITUTED / OTHER INSTRUCTIONS
LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT

Foods to be omitted and substitutions: List specific foods to be omitted **and** foods to be substituted. You may attach a sheet with additional information.

FOODS TO BE OMITTED	FOODS TO BE SUBSTITUTED

☐ **Texture Modification:** _____Pureed _____Ground _____Bite-Sized Pieces _____Other (specify) _____

☐ **Tube Feeding**: Formula Name: _____

Administering Instructions: _____

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

☐ **Other Dietary Modification OR Additional Instructions** (describe): _____

_____ (attach *specific diet order instructions)*

☐ **Infant Feeding Instructions** (if applicable):

SIGNATURE OF LICENSED PHYSICIAN

LICENSED PHYSICIAN MUST SIGN and RETAIN A COPY of this DOCUMENT.

Licensed Physician Name/Credentials (print): _____

Signature:_____ Date: _____

Clinic/Hospital Name: _____

Phone #: _____ Fax #:_____