SPECIAL DIET STATEMENT
For A Participant *Without* a Disability

This Special Diet Statement is for a participant *without* a disability who is medically certified as having a special dietary need. Requests for a special diet must be:

- Supported by a Special Diet Statement that is thoroughly completed and signed by a recognized medical authority (for example: a licensed physician, physician's assistant, certified nurse practitioner, registered dietitian, licensed nutritionist or chiropractor).
- Submitted to the school/center/site before any meal modifications will be made in the United States Department of Agriculture Child Nutrition Programs.

Special diet requests will be evaluated on a case-by-case basis. A school/center/site is encouraged to accommodate reasonable requests but is *not* required to do so.

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:**	**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)

PART 2: PARTICIPANT STATUS
RECOGNIZED MEDICAL AUTHORITY MUST COMPLETE.

Participant does *not* have a disability but is requesting a special meal or dietary accommodation.

Describe and/or select the medical or special dietary condition which restricts the participant's diet:

_____

_____

☐ **Lactose Intolerance:** ☐ No milk to drink (Schools: participant must be offered lactose-reduced or lactose-free milk as required by state law (Minnesota Statutes section 124D.114) when supported by a written request from the parent/guardian.

☐ **Food Intolerance:** Food(s) intolerant to: _____

☐ **Food Allergy:** Food(s) allergic to: _____
The participant's allergy to the food(s) stated above **does not** result in a life threatening (anaphylactic) reaction.
PLEASE NOTE: a food allergy is considered to be a disability when it results in a life-threatening (anaphylactic) reaction.

♦The school/center/site cannot guarantee that the facility or dining area will be allergen free.♦

PART 3: DIETARY ACCOMMODATION
FOODS TO BE OMITTED AND FOODS TO BE SUBSTITUTED / OTHER INSTRUCTIONS
RECOGNIZED MEDICAL AUTHORITY MUST COMPLETE – PLEASE PRINT.

Foods to be omitted and substitutions: List specific foods to be omitted and foods to be substituted.

FOODS TO BE OMITTED	FOODS TO BE SUBSTITUTED

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

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

_____*(attach specific diet order instructions)*

Infant Feeding Instructions:

☐ In place of breast milk or iron-fortified infant formula, infant (age 8-12 months) is approved to be served:

- ☐ whole milk
- ☐ low fat (1%) milk
- ☐ reduced fat (2%) milk
- ☐ nonfat (skim) milk

☐ Infant to be served Non-Iron Fortified Infant Formula (infant under 12 months)

☐ Infant to be served Non-Iron Fortified Infant Cereal (infant ages 4 months to first birthday)

☐ Infant to be served: ☐ Nutramigen ☐ Pregestimil ☐ Alimentum ☐ Other Special Formula _____

☐ Infant to be served a different dilution of formula: _____(Kcal/ounce)

☐ Additional Instructions: _____

_____

SIGNATURE OF RECOGNIZED MEDICAL AUTHORITY

RECOGNIZED MEDICAL AUTHORITY MUST SIGN and RETAIN A COPY of this DOCUMENT.

Recognized Medical Authority Name/Credentials (print): _____

Signature: _____ Date: _____

Clinic/Hospital Name: _____ Phone #: _____