DEPARTMENT OF EDUCATION

Special Diet Statement

Institutions or organizations who sponsor and operate a federally-funded Child Nutrition Program must make accommodations 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 Americans with Disabilities Act (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 U.S. Department of Agriculture (USDA) meal pattern and nutrient requirements are met.

This form must be completed by an authorized medical authority, such as a licensed Physician, Physician Assistant, Advanced Practice Registered Nurse or a Registered Dietitian. 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: _____ Date of Birth: _____

Name of School/Center/Site Attended: _____

Parent/Guardian Name: _____ Phone Number: _____

Required Information: Dietary Accommodation

1. Identify how the participant's physical or mental impairment affects their diet:

2. Describe what must be done to accommodate the participant's dietary needs:

3. If specific foods should be avoided, list those below with recommended substitutions.
   (Do not include specific brand names unless medically necessary)

Foods to be Avoided	Recommended Substitutions

Signature

Authorized medical authority's name (print): _____

Authorized medical authority's credential (select one): ☐ Physician (MD or DO) ☐ Physician Assistant (PA) ☐ Advanced Practice Care Nurse (APRN) ☐ Registered Dietitian (RD or RDN)

Authorized medical authority's signature: _____ Date: _____

Clinic/Hospital: _____ Phone 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 medical authority/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 _____ **(prescribing/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 Signature: _____ Date: _____

or Participant's Signature (Adult Day Care): _____

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 teletypewriter [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: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, 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:

1. **mail:** U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **email:** program.intake@usda.gov

This institution is an equal opportunity provider.