SPECIAL DIET STATEMENT

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

Student's Name: Last / First / Middle Initial	Date of Birth:

Parent/Guardian Name:	WORK / HOME / CELL PHONE NUMBERS

Name of School	Cif #

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

Breakfast Lunch After school Care Program (snack)

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

Section A:

☐ **Student 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.

Identify the Student's disability:_____ AND/OR

Identify the Food allergy that is life-threatening/ anaphylactic reaction. (considered a disability): _____

_____

☐ Has Epi pen _____

Section B:

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

☐ **Lactose Intolerance:** ☐ No milk to drink (Schools offer lactose-reduced or lactose-free milk as required by state law (Minnesota Statutes section 124D.114).

_____

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

_____

☐ **Food Allergy:** Food(s) allergic to: _____

_____

The student'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.

PART 3: DIETARY ACCOMMODATION FOODS TO BE ALLOWED AND FOOD TO BE OMITTED
LICENSED PHYSICIAN MUST COMPLETE. PLEASE PRINT

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

List specific foods to be omitted. You may attach a sheet with additional information.

Category	FOODS ALLOWED	FOODS OMITTED
Bread/ Grain		
Milk		
Fruit /Vegetables		
Meat/Meat Alterative		
Other		

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

_____

☐ **Other Dietary Modification OR Additional Instructions Please include any restricted meal patterns** (describe):

_____

_____
(attach *specific diet order instructions)*

SIGNATURE OF LICENSED PHYSICIAN

Licensed Physician Name/Credentials **(print):** _____

Signature:_____ Date: _____

Clinic Name: _____

Phone #: _____ Fax #:_____