



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 #: _____