OSSEO AREA SCHOOLS

ISD 279

# SPECIAL DIET STATEMENT

**Please attach a copy of your student's lunch menu for the physician to review.**

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

| Student LAST Name: | Student FIRST Name: | Student Middle Initial: | Student Date of Birth: |
|---|---|---|---|
| Parent/Guardian Name: | Home Phone: | Work Phone: | Mobil/Cell Phone: |
| Name of School Student Attends: | | Grade Level: | Date:: |

## PART 2: STUDENT STATUS

**- THIS SECTION MUST BE COMPLETED BY THE LICENSED PHYSICIAN SIGNING THIS FORM**

☐ **Student does NOT have a disability**

☐ **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:_____

Identify the Food Allergy that is Life-threatening/anaphylactic (considered a disability): _____

_____

Identify the "Major Life Activities" affected by the disability: _____

Describe how the disability restricts the student's diet: _____

_____

## PART 3: DIETARY ACCOMMODATION—Food to be allowed and Food to be omitted

**- THIS SECTION MUST BE COMPLETED BY THE LICENSED PHYSICIAN SIGNING THIS FORM**

- **The school cannot guarantee that the facility or dining area will be allergen free . List all food items that must be omitted from the student's diet as well as food items to replace the omitted food items. You must be specific. Attach additional sheet for information if necessary.**

| CATEGORY | FOODS PERMITTED | FOODS THAT MUST BE OMITTED |
|---|---|---|
| **Bread / Grain** | | |
| **Milk / Dairy** | | |
| **Fruit / Vegetables** | | |
| **Meat / Meat Alternate** | | |
| **Other** | | |

- **Texture Modification: _____Pureed _____Ground _____Bite-Size Pieces _____Other:_____**
- **Other Dietary Modification or Additional Instructions or comments about the student's eating or feeding patterns:**

_____

## PART 4: LICENSED PHYSICIAN INFORMATION AND SIGNATURE

**- THIS SECTION MUST BE COMPLETED BY THE LICENSED PHYSICIAN SIGNING THIS FORM**

**Licensed physician must sign and retain a copy of this document for their records.**

Licensed Physician Name / Credentials (Federal law requires signature of MD or DO) - Please Print:

_____

Licensed Physician's Signature:_____ Date:_____

Clinic/Hospital Name:_____

Phone Number:_____ Fax Number:_____

If the School District has any questions regarding the information provided on this form, please list the name, title and phone number of the person the School District should contact if different from the licensed physician signing this form:

_____(Name)/Title) _____(Phone #)

## PART 5: ADDITIONAL PARENT/GUARDIAN INFORMATION

**- THIS SECTION MUST BE COMPLETED BY THE PARENT/GUARDIAN**

Parent/Guardian Street Address:_____ City: _____ Zip Code:_____

Parent/Guardian Signature: _____ Date: _____

**Note to Parent(s)/Guardian(s)/ Student:**

**Return this completed form to the Kitchen Manager of the school your student attends.**

As stipulated in FNA Instruction 783, Rev. 2, Section V Cooperation: When implementing the guidelines of this, school nutrition personnel should work closely with the parents(s)/guardian(s)/student or responsible family member(s) and with all other medical and community personnel who are responsible for the health, well-being and education of a participant with a disability that affects the diet to ensure that reasonable accommodations are made to allow the individual's participation in the meal program.

After review of this Special Diet Statement if more information or clarification is necessary the parent(s)/guardian(s) will be contacted to get this additional information or clarification from the signing physician and an amended form or letter is to be submitted. This information will then be incorporated into an amended Special Diet Statement record.

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director of Adjudication, 1400 Independence Avenue, SW, Washington D.C. 20250-9410 or call toll free (866)632-9922 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339, or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

**School Use Only:**

**Received by (School Nutrition Manager): _____ Date :_____**

**ORIGINAL FORM SHOULD BE SUBMITTED TO THE DISTRICT SCHOOL NUTRITION OFFICE - COPIES ARE TO BE KEPT BY:**

**Site Nurse and the Site Kitchen Manager**

updated: 7/2016