Medical Plan of Care for Special Diets – Participants with Disabilities and Non-Disabling Special Dietary Needs

Division of Food and Nutrition

Institutions or organizations who sponsor and operate a federally-funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a **disability** that restricts their diet and is supported by a statement signed by a recognized **medical authority (licensed physician, physician assistant, or nurse practitioner)**: School Nutrition Program - 7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4). According to the 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. Food allergies which may result in a severe, life-threatening (anaphylactic) reaction may meet the definition of "disability."

Sponsors of these programs 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.

Sponsors may choose to make a milk substitution available for participants/students with a **non-disabling special dietary need.** If these requests are accommodated, sponsors must ensure that all USDA meal pattern and nutrient requirements are met. If available this will be indicated in Part 2. A parent/guardian or **recognized medical authority** may complete this section. If this is the only substitution being requested, complete Part 1 and 2 only.

Part 1: To be Completed by Parent/Guardian (all requests for special dietary needs)

Participants Name ____ Date of Birth ____ ☐M ☐F

Name of School/Center/Day Care Home Program ____ Grade Level/Classroom/Site Number ____

Parent/Guardian's Name ____ Home Phone ____ Work Phone ____

Address ____ City ____ State ____ Zip Code ____

This institution is an equal opportunity provider.

Part 2: Request for Milk Substitution (for non-disabling dietary needs only)

School/school district/center/day care home does not make milk substitutes available to students with non-disabling special dietary needs. Do not complete Part 2.

School/school district/center/day care home provides   as a milk substitute to students/participants with non-disabling or other special dietary needs when Part 2 is completed by Medical Authority or Parent/Guardian and approved by the school/school district/center/day care home.

Does the child/participant have a non-disabling medical or special dietary need that restricts intake of fluid milk? List medical or special dietary need (e.g., lactose intolerance or for cultural or religion beliefs):

____   _______________
Medical Authority or Parent/Guardian Signature   Date

Part 3: To be Completed by Physician/Medical Authority (if participant has a disability)

(If the participant does **NOT** have a disability Part 3 may be completed by a registered dietitian, registered nurse, physician assistant or nurse practitioner) **Disability/Special Dietary Needs:**

Does the child/participant have a disability? ☐Yes ☐No

If yes, please describe the major life activities affected by the disability:

Does the child/participant's disability affect their nutritional or feeding needs? ☐Yes ☐No

If the child/participant does not have a disability, do they have special nutritional or feeding needs? ☐Yes ☐No

(These accommodations are optional for the schools/centers to make.)

If yes, please explain:

If the child/participant has a disability or special dietary/feeding need, please complete Part 4 of this form and have it signed and stamped with the office name and address of a licensed physician/recognized medical authority.

Part 4: **To be completed by Physician/Medical Authority if Participant has a Disability** (If the participant does **NOT** have a disability Part 4 may be completed by a registered dietitian, registered nurse, physician assistant or nurse practitioner.)

List any dietary restrictions, such as food allergies, intolerances or restrictions:

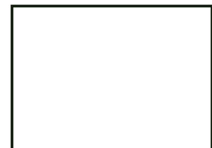
List specific foods to be substituted (Substitution cannot be made unless section is completed):

List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All."

Cut up/chopped into bite sized pieces:
Finely Ground:
Pureed:

List any special equipment or utensils needed:

Indicate any other comments about the child's eating or feeding patterns:



______________________	______________________	
Physician's Name	Office Phone Number	Office Stamp

______________________________ ____________
Physician/Medical Authority's Signature Date

Part 5:

______________________________ ____________
Parent Signature Date

Part 6:

______________________________ ____________
School/center/Day Care Home Program Signature Date

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize ___________________________________*(medical authority)* to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to ___________________________________*(school/program)* and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school/center/day care home 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 my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on________________ *(date).* This information is to e released for the specific purpose of Special Diet Information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

____ ________________
Parent/Guardian Signature **Date**

(**Signing this section is optional** but may prevent delays by allowing us to speak with the physician.)

Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

Parent/Guardian confirmed no change in diet order.

______ Date :________ ______ Date :________ ______ Date :________

______ Date :________ ______ Date :________ ______ Date : ________

______ Date :________ ______ Date :________ ______ Date : ________

Nondiscrimination Statement

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 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/ad-3027.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

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