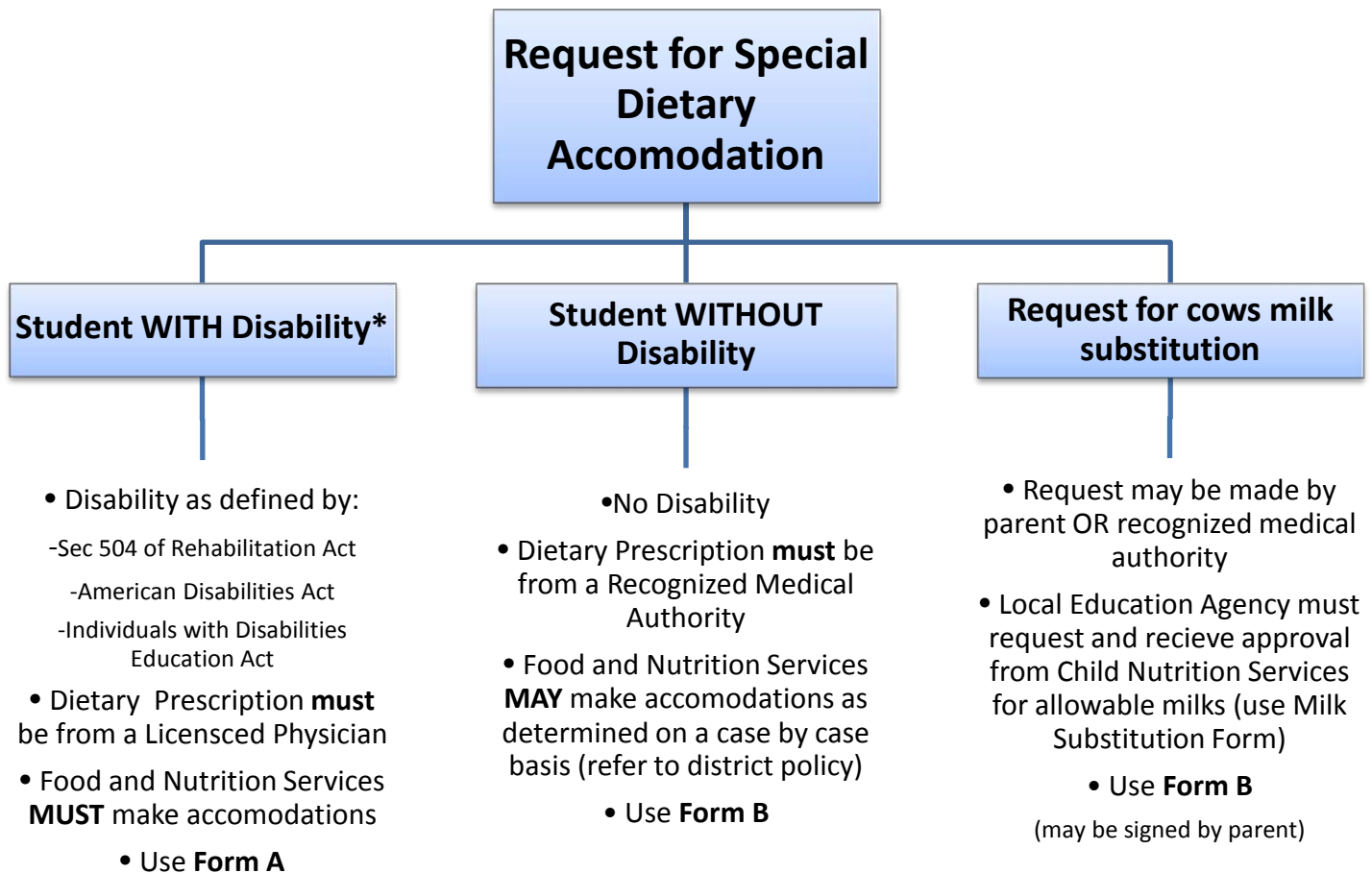


Accommodating Special Dietary Needs

Determining the accommodations to be made AND required documentation



*Disability is determined by a licensed physician

RESOURCES related to Special Dietary requests

- **US Department of Agriculture Food and Nutrition Service**
Accommodating Children with Special Dietary Needs in the School Nutrition Programs Guidance for School Food Service Staff
http://www.fns.usda.gov/cnd/Guidance/special_dietary_needs.pdf
- **Americans with Disabilities Act**
ADA Homepage: <http://www.ada.gov/>
- **US Department of Education link for Individuals with Disabilities Education Act (IDEA)** <http://idea.ed.gov/>

Form A: Dietary Prescription for Student WITH Disability

OSPI Child Nutrition Programs

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name

Birth Date

Age

Grade

School

Parent/Guardian Name

Phone

Mailing Address

City/State/Zip

Signature of Parent/Guardian

Date

DIET ORDER – LICENSED PHYSICIAN MUST COMPLETE and SIGN THIS SECTION.

1. List student's disability: _____
(Include life-threatening allergies which cause an immune system response to a particular food/ingredient/additive.)

2. What is the major life activity(s) affected?

3. Describe how the disability restricts student's diet:

4. List all food(s) and/or milk to be omitted:

5. List all food(s) and/or milk to be substituted:

6. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

7. Describe any other comments about the student's eating or feeding patterns:

Signature of Licensed Physician

Date

E-mail

Phone

Printed Name of Licensed Physician

Address

Form B: Dietary Prescription for Student WITHOUT Disability

OSPI Child Nutrition Programs

IS THIS REQUEST FOR COWS MILK SUBSTITUTION (check box): Yes No

FOR INTERNAL INFORMATION ONLY: If yes, the local education agency must request approval from the Office of Superintendent of Public Instruction - Child Nutrition Services prior to making milk substitutions and must follow USDA regulations. Requests for milk substitutions may be signed by a parent/guardian OR recognized medical authority for students without disabilities.

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

_____	_____	_____	_____	_____
Student Name	Birth Date	Age	Grade	School
_____	_____		_____	
Parent/Guardian Name	Phone			
_____	_____			
Mailing Address	City/State/Zip			
_____	_____			
Signature of Parent/Guardian	Date			

DIET ORDER - RECOGNIZED MEDICAL AUTHORITY MUST COMPLETE and SIGN THIS SECTION.

The definition of a Recognized Medical Authority in Washington State is limited to the following professionals only: Medical Doctor; Doctor of Osteopathy; licensed Physician's Assistant with prescriptive authority; licensed Advanced Registered Nurse Practitioner with prescriptive authority; or licensed Naturopathic Physician.

1. What is the student's special dietary need?

2. List all food(s) to be omitted:

3. List all food(s) to be substituted:

4. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

5. Describe any other comments about the student's eating or feeding patterns:

_____	_____	_____	_____
Signature of Recognized Medical Authority	Date	E-mail	Phone
_____	_____		
Printed Name of Recognized Medical Authority	Address		