Special Dietary Needs Assessment Form

The Child Nutrition Program aims to provide all participating children, regardless of background, with the nutritious meals they need to be healthy. This includes ensuring children with disabilities have an equal opportunity to participate in and benefit from Child Nutrition Programs. The Americans with Disabilities Act defines a person with disability as any person who has a physical or mental impairment which substantially limits one of more “major life activities”, has a record of such impairment, or is regarded as having such impairment. Examples of major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communication, and working. “Major life activities” also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. Additionally, some students may have special dietary request for meal modification, but requests are not related to disability.

Diet modifications must be provided for students with one or more disabilities; however, special diet requests that are not disability related may be accommodated at the discretion of the Foodservice Director.

☐ **New Special Diet Request** ☐ **Change Special Diet on File**

Student Information

Last: ______________________________ First: ___________________________ Student ID___________

Date of Birth: _______________________ School Name ____

Emergency Contact Information

Name: ____ Relationship to Child: _____________________

Daytime Phone: _________________________ Email: ____

Modification Type

Is this modification request related to a student disability?

Please select **yes** if a modification is being requested for the following reasons:

- Modification suggestions are related to a disability and are provided by a State licensed healthcare professional (physician, physician assistant, nurse practitioner (APNP), dentist, optometrist, podiatrist, etc.).

  _____**Yes** My student has an impairment that restricts one or more major life activities and meal modifications are required (**Please complete yellow Section A).**

Please select no if a modification is being requested for the following reasons:

- A child’s family requests meal substitutions for reasons not caused by a disability (ex. religious preferences, lifestyle preference, taste preferences, etc.)
- A medical statement is provided by a non-Licensed healthcare professional (registered nurse, nutritionist, etc.).

  _____ **No** This diet modification is not caused by a disability (**Please complete green Section B).**

Modification Information

If modification is needed for disability related reasons, please complete section A. If modifications are requested for non-disability related reasons, please complete section B.

Section A: Disability Related Modification Request (to be completed by a licensed medical provider)

1. Please provide a description of the child's physical or mental impairment that is sufficient to allow the Foodservice Director to understand how it restricts the child's diet. The specific disability diagnosis is not required to be stated. If this request is related to an allergen, list which allergen should be avoided.
 ____
 ____

2. Provide an explanation of what must be done to accommodate this request. List all foods that need to be omitted or substituted and provide suggestions for acceptable alternatives.
 ____
 ____
 ____

3. Do the foods need to be restricted as a whole food product or ingredient? Please explain. Example: A child cannot eat scrambled eggs but may eat products containing eggs as an ingredient.____
 ____

4. If the diet request is allergen related, please provide an explanation of how the food may impact the student. Select all symptoms that may apply as a result of eating the specified food (s).
 - ○ Tingling or itching in the mouth
 - ○ Hives, itching or eczema
 - ○ Swelling of the lips, face, tongue and throat or other parts of the body
 - ○ Wheezing, nasal congestion or trouble breathing
 - ○ Abdominal pain, diarrhea, nausea or vomiting
 - ○ Dizziness, lightheadedness or fainting
 - ○ Other - Please describe. ____

5. Are texture modifications needed? If yes, please explain.
 ____
 ____

6. Does this child require caloric modifications, use of a liquid nutritive formula, or specific name-brand products? If yes, please provide details on the diet regimen.
 ____
 ____

7. List any additional recommended substitutions or suggestions pertaining to diet modification.
   ____
   ____

Provider's Name: ____

Provider's Phone Number____

Provider's Signature: _________________________________**Date:** ___________________

<u>Section B</u>: Non-Disability Related Modification Request
(to be completed by a parent/guardian)

1. Please list all foods that are requested to be omitted or substituted.
   ____
   ____

2. Do the foods need to be restricted as a whole food product or ingredient? Please explain. Example: A child cannot eat scrambled eggs but may eat products containing eggs as an ingredient.
   ____
   ____

3. Please list any additional modification requests pertaining to diet modification.
   ____
   ____

Parent Signature: ____

Date: ____________________________________

For Internal Use Only:

☐ **Approved**

☐ **Denied**

Reason for denial: ____

____

Foodservice Director Signature: ____

Date: ____________________________________