Aramark
Child Nutrition Programs Special Diet Form

Guidelines for Students with Special Diets

If your child has been identified by a physician to require a specialty diet, changes can be made to your child's meals at no extra charge.

Children will be considered eligible based on the following:

- ☐ Rehabilitation Act of 1973 and the Americans with Disabilities Act
- ☐ Individuals with Disabilities Education Act

U.S. Department of Agriculture (USDA) regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. School food authorities must provide modifications for children with disabilities on a case-by-case basis when requests are supported by a written statement from a state licensed medical practitioner. The licensed medical practitioner's statement must identify:

- an explanation of how the child's physical or mental impairment restricts the child's diet;
- the food(s) to be avoided; and
- the food or choice of foods that must be substituted.

Student Information

First Name: _____ Last Name: _____ Date: _____

Student ID #: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian Name: _____ Email: _____

Medical Information

This school/facility participates in a federally funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable meal accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable meal accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form.

If you have any questions, please contact Jose Saenz, MDS, RDN, LD at Jose.Saenz@gccisd.net.

THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN ONLY.

Does the student have an identified disability, food allergy, or food intolerance requiring a special diet?

- ☐ **Severe Allergy:** Student has a food allergy that is severe or causes an anaphylactic reaction.
- ☐ **Mild Allergy:** Student has a food allergy that is less severe or does not cause an anaphylactic reaction.
- ☐ **Food Intolerance:** Student has a food intolerance that requires a modified diet.
- ☐ **Disability:** Student has a disability that requires a modified diet.
- ☐ Other: _____

Please complete all sections below that are applicable to the child		
Allergies, Intolerances & Celiac Disease	What food(s)/type(s) of food should be omitted? Please be specific.	
	List of foods to be substituted. (Avoid brand names, if possible.)	
If Milk or Eggs:	If milk, does the student have a milk protein allergy or lactose intolerance? ☐ Milk protein allergy ☐ Lactose intolerance Can the student tolerate milk used as an ingredient in cooked foods? ☐ Yes ☐ No Can the student tolerate eggs used as an ingredient in cooked foods? ☐ Yes ☐ No	
Texture Modifications	The child requires that all foods be: ☐ Pureed ☐ Diced/Finely Ground ☐ Chopped/cut into bite sized pieces ☐ Other: _____	Liquids should be: ☐ Pudding Thick ☐ Honey Thick ☐ Nectar Thick ☐ Thin/Normal consistency
Other	What food(s)/type(s) of food should be omitted? Please be specific.	
	List of foods to be substituted. (Avoid brand names, if possible.)	

Additional Comments (If student no longer has any allergies, please note that here):

Signature Required: Please check the appropriate title:	☐ Physician ☐ Physician Assistant	☐ Nurse Practitioner ☐ Dentist	

I certify that the above-named student requires food substitutes as a described above due to their disability, food allergy, or food intolerance.

Medical Practitioner's Name: _____

Medical Practitioner's Signature: _____

Title: _____

Phone Number: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (please print): _____ Phone: _____