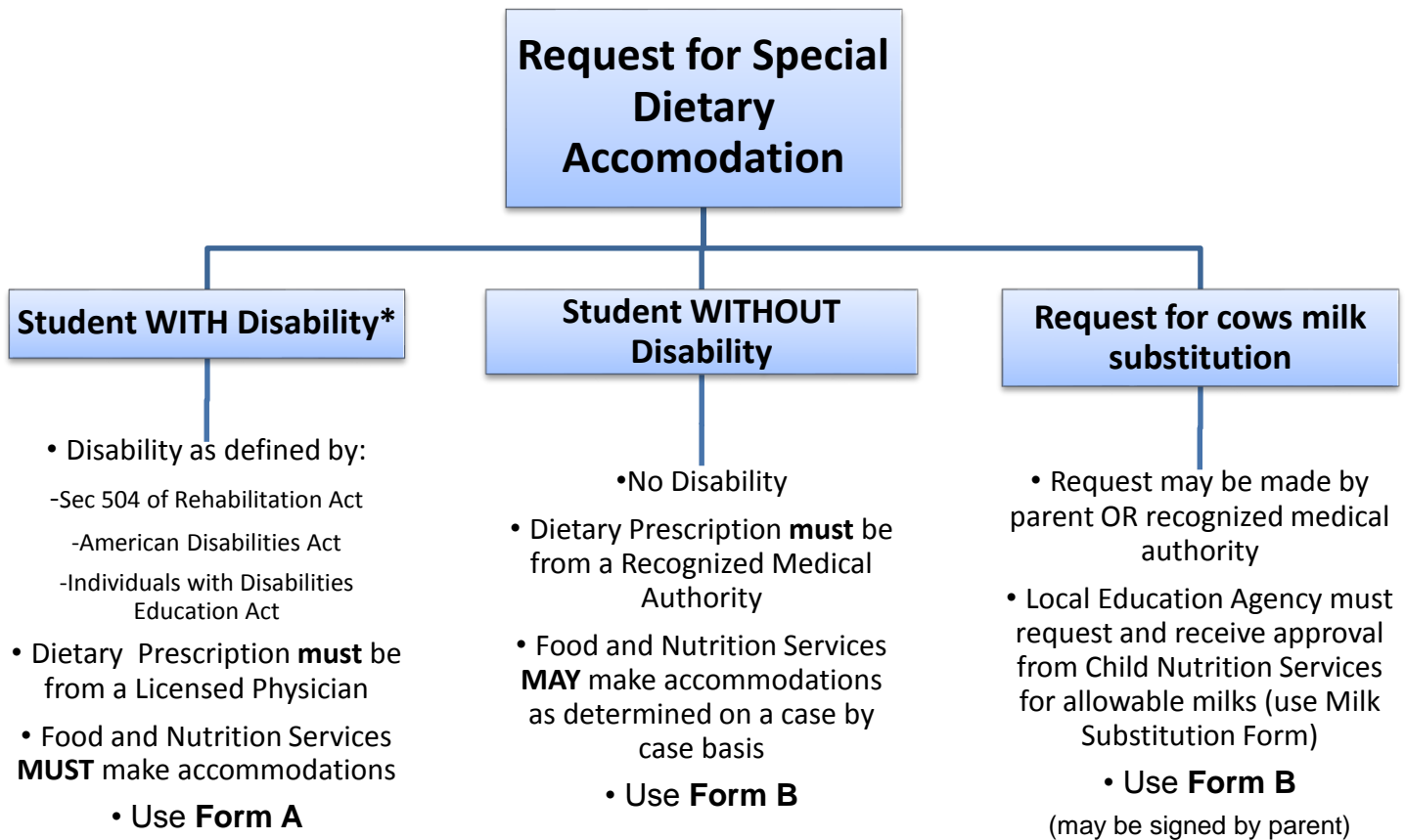


# Accommodating Special Dietary Needs

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](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