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 Nai	me:	Last Name:	Date:					
i ii St ivai	nc	Lust Nume.	Date.					
Student	ID #:		Date of Birth:					
School:		Grade:	Teacher:					
Parent/0	Guardian Name:		Email:					
Medical Information								
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								
your phy	ysician to complete and	sign this form.						
your phy	ysician to complete and	sign this form.	(name) at					
your phy	ysician to complete and ave any questions, pleas THIS SECTION	e contact	(name) at	(phone).				
your phy If you ha	ysician to complete and ave any questions, pleas THIS SECTION e student have an identi Severe Allergy: Student	sign this form. contact N MUST BE COMPLETED BY A fied disability, food allergy, or has a food allergy that is seven	(name) at LICENSED PHYSICIAN ONLY. food intolerance requiring a sp re or causes an anaphylactic re	(phone). Decial diet? Paction.				
your phy If you ha	ysician to complete and ave any questions, pleas THIS SECTION e student have an identi Severe Allergy: Student Mild Allergy: Student have	sign this form. contact N MUST BE COMPLETED BY A fied disability, food allergy, or has a food allergy that is seven	(name) at LICENSED PHYSICIAN ONLY. food intolerance requiring a sp re or causes an anaphylactic re vere or does not cause an anap	(phone). Decial diet? Paction.				
Jour physical physica	rysician to complete and ave any questions, pleas THIS SECTION e student have an identi Severe Allergy: Student had allergy: Student had be student had be student had be student had be sood intolerance: Student had be soon as the sound intolerance and so	sign this form. contact N MUST BE COMPLETED BY A fied disability, food allergy, or has a food allergy that is seven	(name) at	(phone). Decial diet? Paction.				

Please complete all sections below that are applicable to the child							
gies, inces & 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.)						
Allergies, Intolerances & Celiac Disease							
Diabetes Mellitus	Please describe ar	ny modifications necessary	to accommodate th	e child's needs.			
The child requires Other:		☐ Pudding Thick					
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:							
Signature Required: Please check the appropriate title:		☐ Physician ☐ Physician ☐ Assistant ☐	Nurse Practitioner Dentist	□ Podiatrist□ Optometrist			
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 Signa	ture:		Date:				
Parent/Guardian Name	e (please print):		_ Phone	Phone:			