**Special Dietary Needs Form**

The U.S. Department of Agriculture’s (USDA) nondiscrimination (7 CFR 15 b), as well as the regulations governing the National School Lunch Program and School Breakfast Program, make it clear that substitutions to the regular meal must be made for children who are unable to eat school meals because of their disabilities, when that need is certified by a licensed physician.

**Please complete each section of this form and return to Monmouth-Roseville Foodservices**

**Fax (309) 734-3123 Attention: Teresa Allen**

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| **PART A** | | | |
| Student’s Name | Age | Parent’s Name and Phone Number | |
| Name of School: | Grade | Homeroom Teacher | |
| Does the child have one of the following Disabilities? (indicate by circling in the list below) | Does the disability limit one or more major life activities? (indicate by circling in the list below) | | Does the disability cause the child to have special nutritional or feeding needs? |
| Orthopedic Impairment  Visual, speech, and/or hearing impairments  Celiac disease  Sickle cell anemia  Food anaphylaxis (severe food allergy)\*  Autism  Specific learning disabilities; please specify  Multiple Disabilities  Other Disability not listed; please specify  **Health impairments due to**  Asthma  Diabetes  Nephritis  Epilepsy  Hemophilia  \****This does not include non-immune system reactions which is typical with many food intolerances, or slight allergy; only life threatening allergy(such as those that cause respiratory distress)*** | Caring for One’s  Self  Eating  Performing  Manual Tasks  Walking  Seeing  Hearing  Speaking  Breathing  Learning  Working | | Yes, certain foods should be avoided  **COMPLETE PART C**  Yes, foods should be prepared in a certain manner to achieve proper texture and/or consistency for consumption.  **COMPLETE PART D**  No  **CONTINUE PART B** |
| USDA regulations require schools to make accommodations for those with disabilities that require special diet within a reasonable cost to the school food authority. In some cases, special diets may be cost prohibitive to be provided in the school meal program | | | |

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| **PART B** | |
| Does the child have a food allergy (NOT anaphylaxis) or intolerance that requires a special diet?  This does **NOT** include personal preferences.  **THIS SECTION FOR ISSUES OTHER THAN THOSE RELATED TO DIABILITY INDICATED IN PART A** | Yes COMPLETE PART C  No |
| USDA regulations do NOT require schools to accommodate food intolerances. The school food authority retains the right to reject requests for accommodating food intolerances. Any accommodations made for intolerances must comply with the USDA approved meal pattern for school meals. | |

**Special Dietary Needs Form-continued**

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| Student’s Name | Age | | Parent’s name and phone number | |
| **Part C** | | | | |
| **FOODS or INGREDIENTS TO AVOID**  Indicate by circling items in the list below , add items as needed | | **FOODS TO SUBSTITUTE**  Indicate by circling items in the list below, add items as needed. The foods listed are approved as reasonable substitutions in the MRCUSD Food Services. | | |
| MILK, fluid milk only  MILK AND DAIRY presented as whole foods only(includes cheese as a major portion of a dish, i.e. pizza, cheese on a sandwich, or macaroni&cheese)  MILK AND DAIRY as an ingredient in other foods; includes all forms and derivatives of milk  EGG, true form only  EGG as an ingredient in other foods; includes all forms and derivatives  Peanuts  Tree Nuts  Soy  Wheat  Fish  Crustacean shellfish(shrimp)  Peaches Grapefruit  Gluten  **OTHER: (list below, be specific)** | | LACTOSE FREE MILK  **This is the only substitution for an intolerance or non-life threatening allergy to milk**  Apple  Applesauce  Black beans  Carrots, fresh or cooked  Cheese, American  Cheese, Cheddar  Cheese, String  Corn  Ham, turkey deli, sliced  Mandarin Oranges, oranges  Peas  Peaches, diced  Pears, diced  Potatoes  Rice  Tossed Salad  Turkey, deli sliced | | Juice 100%  Fruit Punch  Grape  Orange  Apple |

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| **PART D** |
| Please give detailed description of proper texture/consistency required. List any special equipment or utensils that may be needed (attach separate sheet if more space is needed) |

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| **Other Info & Authorization** | |
| Indicate any other comments about the child’s eating or feeding patterns (attach a separate sheet if more space is needed). | |
| **Please complete attached medication authorization form if emergency medication is needed at school** | |
| List the professional to be contacted if more information or clarification is required (MD, DO, RD, RN, DTR)  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Parent’s Signature: | Date: |
| Physician or Medical Authority Signature: | Date: |