Special Diet Statement

Belgrade School District must make reasonable substitutions to meals on a case-by-case basis for children who are considered to have a disability that restricts their diet [7 CFR 210.10(m)]. According to the ADA Amendments Act, most physical and mental impairments will constitute a disability.

Belgrade School District is not required to accommodate special dietary requests that do not constitute a disability, including requests related to religious or moral convictions or personal preference. If these requests are accommodated, they must ensure all USDA meal pattern and nutrient requirements are met. This form is to be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. Updates to this form are required only when a child’s needs change. Note: Parents may provide a request for lactose-free milk if their child is lactose intolerant without a physician’s signature. See Lactose Intolerant Form at bsd44.org.

Participant Information (Completed by Parent/Guardian)

Student’s Name: ___________________________ Date of Birth: _______________

(Last/First/Middle Initial)

Name of School/Site Attended & Grade: ___________________________ Today’s Date: __________

Parent/Guardian Name: ___________________________________________

Home/Cell Phone Number: __________________ Work Phone Number: ______________

Required Information: Dietary Accommodation (Completed by Licensed Physician)

1. State the student’s dietary restrictions and all food allergies:

________________________________________________________________________

Do any of the above listed items constitute a disability (according to pertinent statutes)? Yes or No (Circle One)

If yes, indicate which one(s):

________________________________________________________________________

2. Brief explanation of how exposure to this food/foods affects the student:

________________________________________________________________________

3. List specific foods to be omitted and the requested accommodations. Attach a sheet with additional instructions as needed.

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<thead>
<tr>
<th>Foods to be Omitted</th>
<th>Requested Accommodations</th>
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Additional Information

[ ] Texture Modification: [ ] Pureed [ ] Ground [ ] Bite-Sized Pieces [ ] Other _________________

[ ] Tube Feeding: Formula Name: __________________________________________________________________

Administering Instructions:

________________________________________________________________________

Oral Feedings: [ ] No [ ] Yes If yes, specify foods allowed: __________________________________________________________________
**Signature (Completed by Licensed Physician)**

Licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner must sign and retain a copy of this document.

Prescribing Authority Name and Credentials (print): ____________________________ Date: ______________

Signature: ____________________________ Clinic/Hospital: ____________________________

Phone Number: _______________________ Fax Number: ____________________________

Office Stamp: ________________________

**Voluntary Authorization (Completed by Parent/Guardian)**

Note to Parent(s)/Guardian(s)/Participant: You may authorize the director of the school/site to clarify this Special Diet Statement with the physician by signing the following Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize ____________________(physician/medical authority name) to release such protected health information as is necessary for the specific purpose of Special Diet information to ________________________ (program name) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet accommodation for my student. I understand that permission to release this information may be rescinded at any time except when the information has already been released. This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian: ____________________________ Date: ______________
Parental Waiver for Dietary Accommodations (Completed by Parent/Guardian)

If you voluntarily elect to waive the required dietary accommodations implemented by Belgrade School Food Service regarding your student’s food allergies, and want to allow your student to purchase and consume food products that may contain any amounts of the documented food allergy please complete the following waiver.

Describe the food products that you desire to allow your student access to & why you wish to waive the required dietary accommodations (using as much detail as possible):

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

[ ] I understand that by providing my signature below, I waive any responsibility and liability on the part of Belgrade Public Schools and Food Service Staff for any adverse events (i.e. anaphylactic shock) that may occur to my student due to my above stated request to waive the required dietary accommodations otherwise implemented by Belgrade School Food Service.

Parent/Guardian Name (Printed): ____________________________________________

Parent/Guardian Signature: ____________________________________________

Date: __________________

Please submit your completed form to your student’s school nurse.

Please contact Belgrade Food Service at 406-924-2516 with any questions or concerns.

Documentation of Accommodations Made (Completed by Head Cook/Food Service Director)

[ ] This document was obtained and reviewed on ____________ (Today’s Date). The dietary accommodations that will be made include:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Food Service Director Signature: ____________________________ Date: __________

School Nurse Signature: ________________________________ Date: __________

Head Cook Signature: _________________________________ Date: __________