

Flat Rock-Hawcreek Schools Food Service Department

Special Diet Request Form

The USDA nondiscrimination regulation (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 regular meals must be made for children who are UNABLE to eat school meals because of their disabilities, when the need is certified by a licensed physician.

Please return completed form to the school nurse OR the Food Service Dept. at 9423 N State Road 9, Hope IN 47246. Conferences with the School Nurse, Cafeteria Manager, and Food Service Director may be held to discuss the child's needs. Please call the Food Service Director or school nurse with any questions or concerns.

Student Name: _____

Date of Birth: _____

School: _____

Grade: _____

Parent/Guardian: _____

Phone: _____

PART A- Non-Disability Food Allergies and Special Diet Requests	
<p>Does the child have a food allergy (not anaphylaxis) or intolerance that requires a special diet? This does NOT include personal preferences.</p> <p>Foods to Avoid: _____</p> <p>_____</p>	<p><input type="checkbox"/> Yes. COMPLETE PART C</p> <p><input type="checkbox"/> No.</p>
<p><small>Per USDA regulations, the school food authority retains the right to reject requests for accommodating non-disability related special diets. Special diet accommodations must comply with the USDA approved meal pattern for school meals.</small></p>	

PART B- Disabilities Restricting Diet (MUST BE COMPLETED BY MEDICAL AUTHORITY)	
<p>Does the child have a disability that requires a special diet?</p> <p><input type="checkbox"/> Orthopedic Impairment</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Phenylketonuria (PKU)</p> <p><input type="checkbox"/> Celiac Disease</p> <p><input type="checkbox"/> Food Anaphylaxis (severe food allergy)*</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Other Disability, please specify _____</p> <p><input type="checkbox"/> No Disability</p>	<p>Does the disability cause the child to have special nutritional or feeding needs?</p> <p><input type="checkbox"/> Yes, certain foods should be completely avoided. COMPLETE PART C</p> <p><input type="checkbox"/> Yes, foods should be prepared to achieve proper texture and/or consistency OR adaptive equipment is needed for feeding. COMPLETE PART D</p> <p><input type="checkbox"/> No.</p>
<p><small>*This does not include non-immune system reactions typical with many food intolerances or allergies, only life threatening allergies, such as those that cause respiratory distress.</small></p>	

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PART C- Meal Pattern Substitutions for Disabilities (MUST BE COMPLETED BY MEDICAL AUTHORITY)
List foods or ingredients to AVOID:
List foods or ingredients to be SUBSTITUTED:

PART D- Texture and Consistency Modifications/Adaptive Equipment
Please give detailed description of proper texture and/or consistency required. List any special equipment or utensils that may be required for the child's feeding.

PART E- Other Information and Authorization	
Include any other comments about child's eating or feeding needs:	
List the medical professional to be contacted if more information or clarification is required.	
Name: _____	Title _____
Telephone: _____	Email: _____
Parent Signature	Date
Medical Authority Signature (REQUIRED FOR FOOD SUBSTITUTIONS)	Date

OFFICE USE Copies to: ☐ ☐ Nurse ☐ ☐ Food Service Office ☐ ☐ Cafeteria

Revised April 2017