

Providing Meals to Children and Adults with Special Dietary Needs

Agencies participating in a federal Child Nutrition Programs (School Meals, Child and Adult Care Food Program, Special Milk, and Summer Food Service Program) are required to make reasonable accommodations for children and adults who have a disability that restricts their diet, including food allergies. The Americans with Disabilities Act defines *disability* as “a physical or mental impairment that substantially limits one or more major life activities” or bodily functions of an individual. This definition is intentionally broad and covers most physical and mental impairments, including temporary or episodic impairments.

Licensed Medical Authority’s Statement for Children with Disabilities

The Department of Agriculture (USDA) regulations require substitutions or modifications of meals for children and adults whose disabilities restrict their diets. Agencies participating in Child Nutrition Programs must provide modifications for children and adults, on a case-by-case basis, when requests are supported by a written statement from a State licensed medical authority. In Maryland this includes, but is not limited to, Physicians, Physician Assistants, Nurse Practitioners, Dentists, and Dietitians.

The written medical statement must include:

- An explanation of how the child or adult’s physical or mental impairment restricts their diet;
- An explanation of what must be done to accommodate the child or adult; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

Other Special Dietary Needs

Agencies may make food substitutions for individuals who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA’s meal pattern requirements. Agencies are encouraged, but not required, to have documentation on file when making menu modifications within the meal pattern.

Special dietary requests, including those related to general health concerns, personal preferences, and moral or religious convictions, are not disabilities and are optional for agencies to accommodate. Changes to meals that are made for non-disability reasons must meet meal pattern requirements in order to be claimed for reimbursement.

General Guidance:

Families and caregivers requesting accommodation should work with appropriate agency staff, such as the menu planner, dietitian, or food service supervisor, to ensure there is appropriate documentation and that the needs of participants are met. The following page is a template that contains all the required elements of a medical statement. Agencies and/or medical authorities may choose to use a different form, as long as it contains all of the required information.

Diet Modifications for Children or Adults with a Food Allergy or Other Disability*

Name of Child/Adult Participant:

_____ Include a brief description of the physical or mental impairment that requires a diet modification:

—

FOODS TO BE *OMITTED* and *SUGGESTED SUBSTITUTIONS*:

Please check the food group(s) to be omitted. List specific foods to be omitted and suggest substitutions. Use the back of this form or attach additional information as needed.

FOODS TO OMIT

SUGGESTED SUBSTITUTIONS

- | | |
|---|--|
| <input type="checkbox"/> Milk/Dairy Products _____ | <input type="checkbox"/> |
| <input type="checkbox"/> Eggs/Egg Products _____ | <input type="checkbox"/> |
| <input type="checkbox"/> Wheat/Wheat Products _____ | <input type="checkbox"/> |
| <input type="checkbox"/> Soy/Soy Products _____ | <input type="checkbox"/> Peanuts |
| _____ | <input type="checkbox"/> Tree Nuts |
| _____ | <input type="checkbox"/> Fish _____ |
| _____ | <input type="checkbox"/> Shellfish _____ |
| _____ | <input type="checkbox"/> Other _____ |

TEXTURE REQUIRED: Regular Chopped Ground Pureed Other detailed information regarding diet or feeding (attach additional information as needed):

I certify that the above named individual needs diet modifications as described above because of the specified food allergy or other disability*:

_____ Signature of
Physician or State Licensed Medical Professional Office Phone Date

Printed Name of Physician or State Licensed Medical Professional

I understand that if medical needs change, it is my responsibility to notify the school/child care/adult day care provider and to submit an updated Diet Modification Form. I give my permission to share the information on

this form with the individuals who take part in the care of the above named individual.

Participant/Parent/Guardian's Signature Home Phone Date

*The Americans with Disabilities Act defines *disability* as “a physical or mental impairment that substantially limits one or more major life activities” or bodily functions of an individual.

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This institution is an equal opportunity provider.