Child Nutrition & Employee Wellness
94 Panther Drive
Yazoo City, MS 39194

Sade' McGee, Coordinator
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Special Dietary Needs Information Form

The Child Nutrition Programs aim to provide all participating children, regardless of background, with the nutritious meals they need to be healthy. This includes ensuring children with disabilities have an equal opportunity to participate in and benefit from Child Nutrition Programs. Additionally, some students may have special dietary request for meal modification, but requests are not related to disability.

Diet modifications must be provided for students with disability; however, special diet requests that are not disability related may be accommodated at the discretion of the School Food Authority.

☐ New Special Diet Request ☐ Change Special Diet on File

Student Information

Name, Last: _____ First: _____ Student ID_____

Date of Birth: _____ School_____

Emergency Contact Information

Name: _____ Relationship to Child: _____

Daytime Phone: _____ Email: _____

Modification Type

Is this modification request related to a student disability?

_____ Yes. My student has an impairment that restricts eating and/or feeding and meal modifications are required. **Please complete Section A.**

Please select yes if a modification is being requested for the following reasons:

- Modification suggestions are related to a disability and are provided by a State licensed healthcare professional (physician, physician assistant, nurse practitioner (APNP), dentist, optometrist, podiatrist).

_____ No. This diet modification is not caused by a disability. **Please complete Section B.**

Please select no if a modification is being requested for the following reasons:

- A child's family requests meal substitutions for reasons not caused by a disability (ex. Religious or ethnic preferences, lifestyle preference, etc.)

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- A medical Statement not valid for a disability is provided or a medical statement is provided by a non-Licensed healthcare professional (registered nursed, dietitian, etc.).

Modification Information If modification is needed for disability related reasons, please complete section A. If modifications are requested for non-disability related reasons, please complete section B.
Section A: Disability Related Modification Requests **(to be completed by a licensed medical provider)**

Provide an explanation of the medical impairment (not necessarily the specific diagnosis) or the allergen(s) that needs to be avoided.

_____

_____

List all foods that need to be omitted or substituted and provide suggestions for acceptable alternatives.

_____

_____

_____

Do the foods need to be restricted as a whole food product or ingredient? Please explain.
Example: A child cannot eat scrambled eggs but may eat products containing eggs as an ingredient.

_____

_____

Please provide an explanation of how the food impacts the student. Select any symptoms that may occur as a result of eating the specified foods.

- ☐ Tingling or itching in the mouth ☐ Hives, itching or eczema
- ☐ Swelling of the lips, face, tongue and throat or other parts of the body
- ☐ Wheezing, nasal congestion or trouble breathing
- ☐ Abdominal pain, diarrhea, nausea or vomiting
- ☐ Dizziness, lightheadedness or fainting
- ☐ Other - Please describe. _____

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Are texture modifications needed? If yes, please explain.

_____

_____

Does this student require caloric modifications, use of a liquid nutritive formula, or specific name-brand products? If yes, please explain.

_____

_____

Please list any additional recommended substitutions or suggestions pertaining to diet modification.

_____

_____

Provider's Name: _____ Provider's Phone Number_____

Provider's Signature: _____Date: _____

Section B: Non-Disability Related Modification Request
(to be completed by a parent/guardian)

Please list all foods that are requested to be omitted or substituted.

_____

_____

Do the foods need to be restricted as a whole food product or ingredient? Please explain. Example: A child cannot eat scrambled eggs but may eat products containing eggs as an ingredient.

_____

_____Please list any additional substitution requests pertaining to diet modification.

_____

_____

Signatures

Signature of Parent: _____ Date: _____

Signature of SFSA: _____ Date: _____

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For Internal Use Only:

☐ Approved

☐ Denied

Reason for denial: _____

_____

_____